IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

NATALIE M. GRIDER, M.D. and KUTZTOWN FAMILY MEDICINE, P.C., Plaintiffs v. KEYSTONE HEALTH PLAN CENTRAL, INC., HIGHMARK INC., JOHN S. BROUSE, CAPITAL BLUE CROSS, JAMES M. MEAD and JOSEPH PFISTER Defendants	)	Civil Action No. 2001-CV-05641

* * *

APPEARANCES:

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FRANCIS J. FARINA, ESQUIRE
On behalf of Plaintiffs

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On behalf of Defendants
Keystone Health Plan Central, Inc., and
Joseph Pfister

DANIEL B. HUYETT, ESQUIRE
On behalf of Defendants
Capital Blue Cross and
James M. Mead

SANDRA A. GIRIFALCO, ESQUIRE
On behalf of Defendants
Highmark, Inc. and John S. Brouse

* * *

O P I N I O N

JAMES KNOLL GARDNER,
United States District Judge

INTRODUCTION

This matter is before the court on Defendants' Motion to Dismiss filed January 23, 2002.[1] Plaintiffs' Memorandum of Law in Opposition to Defendants' Motion to Dismiss Complaint was filed March 6, 2002. Defendants' Reply to Plaintiffs' Opposition was filed March 22, 2002. Upon consideration of the briefs of the parties and for the reasons expressed in this Opinion we grant in part and deny in part Defendants' Motion to Dismiss.

Specifically, we deny defendants' motion to dismiss based upon Pegram v. Herdrich[2], the McCarran-Ferguson Act[3] and the state-action-immunity doctrine.[4] Defendants' motion to dismiss Count I of plaintiffs' Complaint alleging conspiracy is denied. Defendants' motion to dismiss Count II alleging aiding

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[1] This case was originally assigned to our colleague United States District Judge Anita B. Brody. The case was transferred from the docket of District Judge Brody to the docket of Senior District Judge Thomas N. O'Neill, Jr., on November 16, 2001 and from the docket of Senior Judge O'Neill to the undersigned on December 19, 2002.

[2] 530 U.S. 211, 120 S.Ct. 2143, 147 L.Ed.2d 164 (2000).

[3] 15 U.S.C. § 1012.

[4] See Parker v. Brown, 317 U.S. 341, 63 S.Ct. 307, 87 L.Ed. 315 (1943).

and abetting RICO[5] violations is granted. Defendants' motion to dismiss Count III alleging illegal investment of racketeering proceeds under 18 U.S.C. § 1962(a) is granted without prejudice to file an amended complaint. Defendants' motion to dismiss Count IV is granted in part and denied in part relating to allegations of fraud, extortion, bribery and violations of the Travel Act[6] and Hobbs Act.[7] Defendants' motion to dismiss Count V alleging a violation of the Pennsylvania Quality Health Care Accountability and Protection Act[8] is denied. Defendants' motion to dismiss Count VI alleging violation of a duty of good faith and fair dealing is granted. In all other respects, Defendants' Motion to Dismiss is denied.

BACKGROUND

This case presents a number of novel questions of federal and state law, which the United States Court of Appeals for the Third Circuit and the Supreme Court of Pennsylvania, respectively, have yet to address. Plaintiffs' Complaint seeks monetary damages and equitable relief under RICO[9] (Counts I, II,

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[5] Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. §§ 1961-1968.

[6] 18 U.S.C. § 1952.

[7] 18 U.S.C. § 1951.

[8] Act of May 17, 1921, P.L. 682, No. 284, §§ 2101-2193, as amended, 40 P.S. §§ 991.2101 to 991.2193.

[9] 18 U.S.C. §§ 1961-1968.

III, and IV), and Pennsylvania state law (Counts V and VI).[10]

Based upon the allegations of plaintiffs' Complaint filed October 5, 2001, the pertinent facts are as follows. Plaintiff Natalie M. Grider, M.D. is a family practitioner and President of plaintiff Kutztown Family Medicine, P.C. Plaintiffs and their affiliates provide medical services to about 4,000 patients who are insureds of defendant Keystone Health Plan Central, Inc. ("Keystone"). Plaintiffs bring this action as a proposed class action pursuant to Rule 23 of the Federal Rules of Civil Procedure.

Keystone is a Health Maintenance Organization ("HMO") organized under the Pennsylvania Health Maintenance Organization Act.[11] The Act defines an HMO as an "organized system which combines the delivery and financing of health care and which provides basic health services to voluntarily enrolled subscribers for a fixed prepaid fee." 40 P.S. § 1553.[12]

In their Complaint, plaintiffs contend that defendants

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[10] The Panel on Multi-District Litigation consolidated a series of nearly identical actions in the Southern District of Florida. These actions are divided into two tracks, "provider" and "subscriber," and also involve RICO claims against a "Managed Care Enterprise". The provider-track cases, before United States District Judge Federico A. Moreno, are consolidated as In Re: Managed Care Litigation, MDL No. 1334, No. 00-1334-MD-MORENO. Judge Moreno granted in part and denied in part defendants' motion to dismiss in that case at 135 F. Supp. 2d 1253, 1254 (S.D. Fla. 2001).

[11] Act of December 29, 1972, P.L. 1701, No. 364, §§ 1-17, as amended, 40 P.S. §§ 1551-1567.

[12] Act of December 29, 1972, P.L. 1701, No. 364, § 3, as amended, 40 P.S. § 1553.

Capital Blue Cross ("Capital") and Highmark Inc., ("Highmark") direct and control the operations of Keystone and receive all of its profits. Plaintiffs further contend that defendants, John S. Brouse, James M. Mead and Joseph Pfister are the Chief Executive Officers of Highmark, Capital and Keystone, respectively. Plaintiffs allege that defendants and various non-parties together form what is styled as the "Managed Care Enterprise", an entity which allegedly operates to defraud plaintiffs and other physicians through a variety of illegal methods.

Plaintiffs entered into an HMO-physician agreement with defendant Keystone in December 1998 to provide medical services to the HMO's members. In addition to a complex bonus system, the agreement, which defendants have attached to their motion to dismiss, provides for two basic methods by which plaintiffs are paid for rendering medical services: (1) capitation, and (2) fee for service.

A "capitation" is "an annual fee paid a doctor or medical group for each patient enrolled under a health plan." Webster's Third New International Dictionary 332 (1968). The regularly paid capitation is compensation for the treating physician in lieu of payment when services are actually provided. The theory behind capitation is that the doctor services a group of patients, only some of whom need care in a given month. The capitated payments for the healthy members help to compensate for

the services rendered to the ill members.

In contrast, under the fee-for-service arrangement, plaintiffs are required to submit claim forms to the defendants to receive reimbursement after providing a specific service to an HMO member. In submitting the fee-for-service claim, plaintiffs use a form created by the Health Care Financing Administration and Current Procedure Terminology ("CPT") code developed by the American Medical Association to describe the services performed for the insured patient.

Plaintiffs allege a variety of ways in which defendants used the mail and wires to defraud plaintiffs by wrongfully delaying and denying compensation due under both methods of payment. Generally, plaintiffs assert that the HMO-physician agreement contains a number of misrepresentations and material omissions. Specifically, plaintiffs allege that defendants (1) "shave" capitation payments by purposefully under-reporting the number of patients enrolled in plaintiffs' practice group; (2) defraud plaintiffs of fees for medical services rendered by wrongfully manipulating CPT codes to decrease the amount of reimbursements; and (3) defraud plaintiffs of bonuses promised in the HMO-physician agreement.

Plaintiffs also assert a number of RICO claims premised

on extortion in violation of the Hobbs Act,[13] bribery,[14] and violations of the Travel Act.[15] Specifically, plaintiffs allege that defendants committed extortion by using economic fear of retaliation for questioning the allegedly wrongful delay and denial of payments due under the HMO-physician contract and by employing monopoly-like power to force plaintiffs into accepting an unfair adhesion contract or risk financial ruin. In addition, plaintiffs contend defendants violated federal bribery laws by providing incentives to claim reviewers to deny valid claims. Moreover, plaintiffs aver defendants used interstate travel and mail for unlawful activity in violation of the Travel Act.

Finally, plaintiffs allege two state law claims. Plaintiffs assert that defendants violated the prompt-payment provision of Pennsylvania's Quality Health Care Accountability and Protection Act[16] ("Health Care Act") and breached an implied duty of good faith and fair dealing in performing under the HMO-physician contract.

Plaintiffs filed their Complaint in the Court of Common Pleas of Philadelphia County on October 5, 2001. Defendants

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[13] 18 U.S.C. § 1951.

[14] 18 U.S.C. § 1954.

[15] 18 U.S.C. § 1952.

[16] Act of May 17, 1921, P.L. 682, No. 284, §§ 2101-2193, as amended, 40 P.S. §§ 991.2101 to 991.2193.

removed the action to this court on November 7, 2001.

STANDARD OF REVIEW

A Rule 12(b)(6) motion to dismiss examines the sufficiency of the complaint. Conley v. Gibson, 355 U.S. 41, 45, 78 S.Ct. 99, 102, 2 L.Ed.2d 80, 84 (1957). In determining the sufficiency of the complaint the court must accept all plaintiffs' well-pled factual allegations as true and draw all reasonable inferences therefrom in favor of plaintiffs. Graves v. Lowery, 117 F.3d 723, 726 (3d Cir. 1997).

> [T]he Federal Rules of Civil Procedure do not require a claimant to set out in detail the facts upon which he bases his claim. To the contrary, all the Rules require is "a short and plain statement of the claim" that will give the defendant fair notice of what the plaintiff's claim is and the grounds upon which it rests.

Conley, 355 U.S. at 47, 78 S.Ct. at 103, 2 L.Ed.2d at 85. (Internal footnote omitted.) "Thus, a court should not grant a motion to dismiss 'unless it appears beyond a doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief.'" Graves, 117 F.3d at 726 citing Conley, 355 U.S. at 45-46, 78 S.Ct. at 102, 2 L.Ed.2d at 84.

Regarding plaintiffs' fraud claims, Federal Rule of Civil Procedure 9(b) provides in pertinent part: "In all

averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity." Plaintiffs "need not, however, plead the 'date, place or time' of the fraud, so long as they use an 'alternative means of injecting precision and some measure of substantiation into their allegations of fraud.'" Rolo v. City Investing Company Liquidating Trust, 155 F.3d 644, 658 (3d Cir. 1998) quoting Seville Industrial Machinery Corp. v. Southmost Machinery Corp., 742 F.2d 786, 791 (3d Cir. 1984). While the purpose of the rule is to provide notice to defendants of the precise misconduct with which they are charged, courts should apply the rule with some degree of flexibility. Rolo, supra.

SUMMARY OF CONCLUSIONS

Applying these standards, and for the reasons expressed below, we conclude as follows:

Because the holding of the United States Supreme Court in Pegram v. Herdrich, 530 U.S. 211, 120 S.Ct. 2143, 147 L.Ed.2d 164 (2000) is limited, and the facts of Pegram are distinguishable, Pegram does not bar the present suit.

Because Pennsylvania has never intended to bar actions such as those authorized by the federal RICO statute, the McCarran-Ferguson Act does not preclude plaintiffs' RICO claims.

Because the state-action-immunity doctrine does not

constitute a defense to civil RICO actions, is disfavored, and applies only in an antitrust context, the doctrine does not preclude plaintiffs' RICO claims.

Plaintiffs' allegations pertaining to "shaving" patients from the monthly statements, allege predicate acts of fraud for purposes of plaintiffs' RICO claims.

Plaintiffs' allegations of statistically insignificant sampling does not state a claim for fraud because the clear language of the agreement reveals that such a sampling would not occur.

Plaintiffs' allegations pertaining to the quarterly bonuses constitute valid claims for fraud because the agreement's omissions make the rewards promised to physicians unattainable.

Many of plaintiffs' allegations of wire and mail fraud fail because many of defendants' alleged concealments are disclosed in the HMO-physicians agreement, because the omissions cannot be construed as reasonably calculated to deceive persons of ordinary prudence and comprehension, and because some of the allegations fail to satisfy the particularity required by Federal Rule of Civil Procedure 9(b).

Plaintiffs' remaining allegations sufficiently state claims for fraud

- including defendants' alleged misrepresentations that

they would pay plaintiffs for medically necessary services and procedures provided by plaintiffs according to Current Procedure Terminology ("CPT") codes developed by the American Medical Association to describe the services performed for the insured patient;

-and including defendants' alleged concealment of the fact that defendants

(1) provide incentives to claim reviewers to delay or deny payments;

(2) developed or purchased systems designed to manipulate CPT codes;

(3) automatically downcode claims;

(4) automatically bundle claims; and

(5) will not distribute money for participation in risk pools to which plaintiffs claim they are entitled.

Plaintiffs' allegation that defendants threatened to withhold bonuses to which plaintiffs were entitled under the HMO-physician contract unless plaintiffs discontinued complaining about defendants improper "shaving" of plaintiffs' capitation payments, may constitute extortion under the Hobbs Act.

Because plaintiffs have no pre-existing right to be part of defendants' healthcare network, we reject plaintiffs'

claim that defendants are violating the Hobbs Act by exercising such coercive economic power that it is impossible to negotiate (or renegotiate) a fair arms-length contract.

Plaintiffs' allegations that they were wrongfully denied payment of compensation due under the HMO-physician agreement because defendants bribed claim reviewers with illegal bonuses and kickbacks, allege predicate acts of bribery for purposes of plaintiffs' RICO claims.

Plaintiffs' allegations that defendants traveled in interstate commerce in an attempt to commit extortion, allege predicate acts of violation of the Travel Act for purposes of plaintiffs' RICO claims.

Plaintiffs have standing to bring their RICO claims because they have sufficiently pled a concrete financial loss to their business or property by reason of a violation of Section 1962 of the RICO Act.

Plaintiffs have pled a RICO enterprise or its structure with sufficient detail because plaintiffs have identified the parties who make up the enterprise, described how these parties may be associated through financial incentives, and sufficiently alleged that the entities form a continuing unit with a common course of conduct.

Because plaintiffs have not alleged with sufficient

particularity a specific distinct injury flowing from the investment of the proceeds of defendants' alleged misconduct as required by Section 1962(a) of the RICO Act, we dismiss plaintiffs' RICO claims based on that section and grant plaintiffs leave to amend their Complaint.

Because plaintiffs have adequately pled that defendants directed and controlled the managed-care enterprise, as required by Section 1962(c) of the RICO Act, we deny defendants' motion to dismiss with respect to plaintiffs' Section 1962(c) claims.

Because plaintiffs have sufficiently alleged a conspiracy under Section 1962(d) of the RICO Act, we deny defendants' motion to dismiss the conspiracy claim.

Because the United States Court of Appeals for the Third Circuit has foreclosed plaintiffs' claims for aiding and abetting under the RICO Act, we grant defendants' motion to dismiss plaintiffs' claims for aiding and abetting RICO violations.

Finally, we conclude that the Supreme Court of Pennsylvania would recognize an implied private remedy under the Pennsylvania Quality Health Care Accountability and Protection Act but would not impose a separate duty of good faith and fair dealing on an HMO-physician contract.

DISCUSSION

Pegram Argument

As a preliminary matter, defendants assert that the Supreme Court's decision in Pegram v. Herdrich, 530 U.S. 211, 120 S.Ct. 2143, 147 L.Ed.2d 164 (2000) bars this action. Defendants contend that Pegram holds that challenges to the concept of managed care are better asserted in state legislatures than in federal courts. On the contrary, Plaintiffs allege that Pegram does not grant blanket protection to HMOs from attack under federal statutes. In support of their position plaintiffs cite In Re: Managed Care Litigation, 135 F. Supp. 2d 1253 (S.D. Fla. 2001), in which United States District Judge Federico A. Moreno of the Southern District of Florida considered Pegram's application to a set of facts similar to those presented here.

For the following reasons, we conclude that the facts in this case are much closer to those in the Florida decision than to those in Pegram, and we find Judge Moreno's reasoning persuasive.

In Pegram, plaintiff Cynthia Herdrich developed abdominal pain that was later diagnosed as appendicitis. Herdrich's physician, Dr. Lori Pegram, decided to wait eight days for an ultrasound at a facility staffed by Herdrich's HMO, which

was owned by physicians including Dr. Pegram. During the eight-day waiting period, Herdrich's appendix ruptured, causing peritonitis. 530 U.S. at 215, 120 S.Ct. at 2147, 147 L.Ed.2d at 172.

Cynthia Herdrich sued, claiming among other things that the HMO's practice of rewarding its physician-owners for limiting medical care was a breach of fiduciary duty under the Employee Retirement Income Security Act ("ERISA")[17] because the practice encouraged physicians to make decisions motivated by their own self-interest rather than by the exclusive interests of plan participants. 530 U.S. at 215-216, 120 S.Ct. at 2147, 147 L.Ed.2d at 172-173.

The Supreme Court of the United States granted certiorari on the issue "whether treatment decisions made by a health maintenance organization, acting through its physician employees, are fiduciary acts within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA)". 530 U.S. at 214, 120 S.Ct. at 2147, 147 L.Ed.2d at 172. (Citation omitted.)

In evaluating plaintiff's complaint, the Supreme Court recognized that it was not the province of the federal judiciary to "entertain an ERISA fiduciary claim portending wholesale

[17] 29 U.S.C. §§ 1001-1461.

attacks on existing HMOs solely because of their structure, untethered to claims of concrete harm." The Court went further and stated that to entertain such a broadside attack the judiciary "would be acting contrary to the congressional policy of allowing HMO organizations." 530 U.S. at 234, 120 S.Ct. at 2157, 147 L.Ed.2d at 184.

Despite the Supreme Court's admonition regarding congressional policy, the actual holding of Pegram is narrow: "mixed eligibility decisions by HMO physicians are not fiduciary decisions under ERISA." 530 U.S. at 237, 120 S.Ct. at 2158, 147 L.Ed.2d at 186. The Pegram Court defined "mixed eligibility" decisions as instances where the determination of how to treat a patient and whether an HMO plan covered a specific treatment were inextricably mixed. 530 U.S. at 228-229, 120 S.Ct. at 2154, 147 L.Ed.2d at 180-181.[18]

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[18] The Pegram Court explained:

> What we will call pure "eligibility decisions" turn on the plan's coverage of a particular condition or medical procedure for its treatment. "Treatment decisions," by contrast, are choices about how to go about diagnosing and treating a patient's condition: given a patient's constellation of symptoms, what is the appropriate medical response?
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> These decisions are often practically inextricable from one another . . . . The issue may be, say, whether one treatment option is so superior to another under the circumstances, and needed so promptly, that a decision to proceed with it would meet the medical necessity requirement that conditions the HMO's obligation to provide or pay for that particular procedure at that time in that case.

The Supreme Court distinguished mixed decisions from fiduciary decisions by noting that mixed eligibility decisions were not what Congress had in mind when it enacted ERISA. The Court reasoned that "when Congress took up the subject of fiduciary responsibility under ERISA, it concentrated on fiduciaries' financial decisions, focusing on pension plans, the difficulty many retirees faced in getting the payments they expected, and the financial mismanagement that had too often deprived employees of their benefits." 530 U.S. at 232, 120 S.Ct. at 2156, 147 L.Ed.2d at 183, citing S.Rep. No. 93-127, p. 5 (1973); S.Rep. No. 93-383, p. 17 (1973). Hence, the holding in Pegram is based upon the specific policies underlying ERISA.

However, the action before the undersigned is closer to the factual situation described by Judge Moreno in Managed Care. There, plaintiffs were "health care providers from various states who have business relationships with the eight managed care insurance company Defendants." Managed Care, 135 F. Supp. 2d at 1256. Managed Care, unlike Pegram, involved RICO claims, not exclusively ERISA claims.

The present action and Managed Care both include allegations that defendants' policies are "specifically designed to systematically obstruct, reduce, delay and deny payment and

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(Continuation of footnote 18):
530 U.S. at 228-29, 120 S.Ct. at 2154, 147 L.Ed.2d at 180-181.

reimbursements to health care providers." Managed Care, supra. In sum, the key distinctions between Pegram and the present case are that plaintiffs are providers, not patients; the claims involve RICO, rather than exclusively ERISA; and plaintiffs seek redress under existing statutes for concrete harm, rather than mounting a broad-based attack on the HMO structure itself.[19]

We find Judge Moreno's reasoning in Managed Care persuasive in the context of the present action. Specifically, in dismissing the Pegram defense, he wrote that "the Court in Pegram did not fashion an all-encompassing cloak of immunity for the health care industry." Moreover, the "viability of HMO-type structures will not be imperiled if such entities are held accountable for concrete harm flowing from acts of fraud, extortion and breach of contract." 135 F. Supp. 2d at 1258. Because we agree with Judge Moreno that the Supreme Court's holding in Pegram is limited, we conclude that Pegram does not bar the present suit.

Federalism Defenses

Defendants assert two "federalism" defenses. Initially, defendants claim that the RICO claims are barred by

[19] Defendants argue that the far-reaching injunctive remedies sought by plaintiffs reveal that this case is a broad-based attack on the concept of HMOs. Given the list of requested remedies, defendants' alarm is understandable. However, plaintiffs cannot be faulted for asking for all possible remedies at this stage of the action.

the McCarran-Ferguson Act.[20] That act bars actions under federal laws that might interfere with states' regulation of insurance within their borders. Second, defendants raise the state-action-immunity doctrine normally applied in antitrust cases. In this regard defendants assert that federal relief cannot be granted because the state has made legal under its laws the actions which plaintiffs claim are illegal under federal laws.

McCarran-Ferguson Act

The McCarran-Ferguson Act, provides: "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . ." 15 U.S.C. § 1012(b). Defendants contend that the act bars plaintiffs' RICO claims. We disagree because RICO does not, in the context of this action, invalidate, impair or supersede Pennsylvania's insurance laws.

In Sabo v. Metropolitan Life Insurance Company, 137 F.3d 185, 188 (3d Cir. 1998) the Court of Appeals for the Third Circuit set forth a four-part test with respect to McCarran-Ferguson Act preclusion:

> (1) the federal statute under which the allegedly precluded action is brought . . . does not relate specifically to the business of insurance; (2) the complained-of activities

[20] 15 U.S.C. §§ 1011-1015.

> constitute the "business of insurance"; (3) a relevant state has enacted laws for the purpose of regulating these complained-of activities; and (4) application of the federal statute would "invalidate, impair, or supersede such laws."

137 F.3d at 188.

For the following reasons, we conclude that first three prongs of the Sabo test are satisfied here. Plaintiffs admit that RICO is not a law relating specifically to the business of insurance.[21] Moreover, in their memorandum of law, plaintiffs also appear to concede that the complained-of activities could constitute the business of insurance, and that Pennsylvania regulates those activities. Any remaining doubt that the second and third prongs of the Sabo test are established here is dispelled by the Supreme Court's decision in Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002), overruled in part on other grounds, Kentucky Association of Health Plans, Inc., v. Miller, __ U.S.__, 123 S.Ct. 1471, 155 L.Ed.2d 468 (2003).

In Rush, the United States Supreme Court adopted a "commonsense" view that HMOs "have taken over much business formerly performed by traditional indemnity insurers, and . . . are almost universally regulated as insurers under state law", and that "Congress [has] demonstrated an awareness of HMOs as

[21] Plaintiffs' Memorandum of Law in Opposition to Defendants' Motion to Dismiss Complaint, page 36, footnote 1.

risk-bearing organizations subject to state insurance regulation." 536 U.S. at 372-373, 122 S.Ct. at 2163, 153 L.Ed.2d at 2163.

The Court went on to find that an Illinois HMO law, akin to the Pennsylvania HMO Act, 40 P.S. §§ 1551-1567, was "directed toward" the insurance industry and was therefore an "insurance regulation." Rush, supra. Based upon Justice Souter's extensive discussion in Rush of the second and third prongs of the Sabo test, we conclude that those tests are satisfied here. Accordingly, the only factor which saves plaintiffs' RICO claims from preclusion is the fourth Sabo factor.

The fourth part of the Sabo test for preclusion is not easily met. Defendants assert that plaintiffs' RICO claims are no more than a covert attempt to challenge the very managed care concept endorsed by the Pennsylvania legislature, and therefore conflict with state insurance regulations. Plaintiffs respond by citing Humana, Inc. v. Forsyth, 525 U.S. 299, 119 S.Ct. 710, 142 L.Ed.2d 753 (1999).

In Humana, which a unanimous Supreme Court found RICO not to conflict with Nevada's Unfair Insurance Practices Act. Judge Moreno relied on Humana in his Managed Care decision, concluding that the "Court said permitting private civil RICO suits would aid and enhance the state regulation of the insurance

industry." Managed Care, 135 F. Supp. 2d at 1260. Defendants argue that Humana does not apply here because that decision relied on Nevada law which authorized private actions, while Pennsylvania law does not permit such actions. We conclude that Third Circuit precedent holds otherwise.

In Sabo, the Third Circuit Court of Appeals specifically addressed the question of whether a private RICO action conflicted with Pennsylvania's Unfair Insurance Practices Act[22] ("UIPA"), and held that it did not.[23] 137 F.3d at 193-195. The Sabo Court noted that despite the UIPA's lack of a private cause of action, Pennsylvania courts "have not barred common law actions for fraud and deceit arising out of insurance practices." 137 F.3d at 192.

Moreover, in Katz v. Aetna Casualty & Surety Company, the Third Circuit held that common law actions are not preempted by UIPA. 972 F.2d 53, 58 (3d Cir. 1992). The Third Circuit's determination that common law actions are not preempted by UIPA is supported by the Superior Court of Pennsylvania's decision in

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[22] 40 Pa.C.S.A. §§ 1171.1 to 1171.15.

[23] Defendants cite a case from the Eighth Circuit, LaBarre v. Bankers & Shippers Ins. Co., 175 F.3d 640 (8th Cir. 1999), holding that McCarran-Ferguson barred a RICO action where no analogous private right of action existed under state law. (Defendants' Reply to Plaintiffs' Opposition at page 14). Defendants also cite two Virginia district court cases with similar holdings. However, the Third Circuit declined to accept such precedent in Sabo. Instead, the Third Circuit followed First, Seventh and Ninth Circuit precedent and rejected cases from the Fourth, Eighth, and Sixth Circuits. Sabo, 137 F.3d at 193-194.

Pekular v. Eich, 355 Pa. Super. 276, 513 A.2d 427 (1986), which held that common law fraud and deceit actions are not barred by UIPA.

In addition, the Pennsylvania courts' recognition of a private remedy and treble damages for victims of insurance fraud in the state's general consumer protection statute, 73 Pa.C.S.A. §§ 201-1 to 201-9.2, "undercuts any purported balance struck by the Pennsylvania legislature favoring administrative enforcement to the exclusion of private damages actions and we see no reason why a federal private right of action cannot coexist with the UIPA in these circumstances." Sabo 137 F.3d at 195.

In light of Pennsylvania caselaw and state statutes (including that cited by plaintiffs, 42 Pa.C.S.A. § 8371, which authorizes a bad-faith action by an insured), it is clear that the Pennsylvania legislature has not forbidden or even discouraged private actions in the insurance context. Consequently, we conclude there is no direct conflict between RICO and state-law remedies addressing the same or similar proscribed behavior. Pennsylvania has not commanded something the Federal Government seeks to prohibit. See Securities and Exchange Commission v. National Securities, Inc., 393 U.S. 453, 89 S.Ct. 564, 21 L.Ed.2d 668 (1969).

The foregoing logic applies equally to the Pennsylvania

HMO Act. Because Pennsylvania has never intended to bar actions such as those authorized by the federal RICO statute, we conclude that the McCarran-Ferguson Act does not preclude plaintiffs' RICO claims.

State-Action-Immunity Doctrine

Defendants next assert that the state-action-immunity doctrine bars this suit. We disagree because the doctrine does not constitute a defense to civil RICO actions, is disfavored, and applies only in an antitrust context.

The state-action-immunity doctrine, also referred to as the "state-action exemption", grew out of the Supreme Court's landmark decision in Parker v. Brown, 317 U.S. 341, 63 S.Ct. 307, 87 L.Ed. 315 (1943). In that case, the Court held that the Sherman Antitrust Act did not prohibit a California program created by the legislature to restrict competition among raisin producers and to maintain prices. Nonetheless, the Court noted that the "state does not give immunity to those who violate the Sherman Act by authorizing them to violate it, or by declaring that their action is lawful." 317 U.S. at 351, 63 S.Ct. at 314, 87 L.Ed. at 326.

The Supreme Court further clarified the exemption in California Retail Liquor Dealers Association v. Midcal Aluminum, Inc., stating that the restraint on competition that is

challenged must be "clearly articulated and affirmatively expressed as state policy", and must be "actively supervised" by the state itself. 445 U.S. 97, 105, 100 S.Ct. 937, 943, 63 L.Ed.2d 233, 243 (1980). Finally, in Southern Motor Carriers Rate Conference, Inc. v. United States, the Court extended state-action immunity to private parties in certain situations. 471 U.S. 48, 105 S.Ct. 1721, 85 L.Ed.2d 36 (1984).

Defendants argue that the state-action exemption, rooted in principles of federalism, can be exported to RICO actions. To provide a vehicle for this shift, defendants cite the example of the Noerr-Pennington doctrine, which also arose in antitrust law but which has since been applied to RICO actions. Noerr-Pennington immunity, as defendants explain, shields private actors from liability for attempting to influence legislative processes.

The doctrine arose in two Supreme Court decisions in the 1960s, Eastern Railroad President's Conference v. Noerr Motor Freight, Inc., 365 U.S. 127, 81 S.Ct. 523, 5 L.Ed.2d 464 (1961), and United Mine Workers v. Pennington, 381 U.S. 657, 85 S.Ct. 1585, 14 L.Ed.2d 626 (1965). In essence, the Noerr-Pennington doctrine established antitrust immunity based on the First Amendment's guarantee of a right to petition the government. ABA Section of Antitrust Law, 2000 Review of Antitrust Developments 406 (2001).

Defendants assert that because this doctrine has been applied in the RICO context, See International Brotherhood of Teamsters, Local 734 Health & Welfare Trust Fund v. Philip Morris Inc., 196 F.3d 818, 826 (7th Cir. 1999), the state-action-immunity doctrine can also be lifted out of its antitrust arena and applied here. However, Noerr-Pennington immunity is not only based on a powerful First Amendment right, but is more readily transferrable to other legal areas.

There are two reasons to reject defendants' argument that the state-action exemption, like Noerr-Pennington immunity, can be extended to RICO. Initially, we note that the court's own research uncovered no decision extending state-action immunity beyond the antitrust context. Accordingly, granting such an exception here would create an entirely new defense to civil RICO actions that has never been recognized, tried or granted. We decline to carve out such an exception in this matter.

Next, the state-action doctrine is limited even in the antitrust arena. While unmentioned by defendants, the United States Supreme Court in FTC v. Ticor Title Insurance Co., 504 U.S. 621, 641, 112 S.Ct. 2169, 2182, 119 L.Ed.2d 410, 428 (1992) expressed its disdain for the doctrine, stating that state-action immunity is "disfavored, much as are repeals by implication", and that the doctrine would impede state regulatory goals rather than further them. Moreover, in concurrence,

Justice Antonin Scalia declared his skepticism about "state-programmed private collusion in the first place."
504 U.S. at 641, 112 S.Ct. at 2182, 119 L.Ed.2d at 428.

In Ticor, the Supreme Court was greatly influenced by 36 state amicus briefs opposing broad application of state-action immunity:

> Respondents contend that principles of federalism justify a broad interpretation of state-action immunity, but there is a powerful refutation of their viewpoint in the briefs that were filed in this case. [The 36 states that filed amici curiae briefs] deny that respondents' broad immunity rule would serve the states' best interests.

504 U.S. at 635, 112 S.Ct. at 2178, 119 L.Ed.2d at 423.

The Ticor Court held that the state-action exemption could be extended to private parties only in limited circumstances where the activity sought to be immunized is unambiguously an intended, official state policy, actively supervised by state officials. "Actual state involvement, not deference to private pricefixing arrangements under the general auspices of state law, is the precondition for immunity from federal law." 504 U.S. at 633, 112 S.Ct. at 2176, 119 L.Ed.2d at 422.

In this case, the state is not actively involved in the complained-of activities. While Pennsylvania does provide for

contracts between HMOs and providers,[24] the legislature in 1996 repealed the portion of the HMO Act that provided for state approval of rates and forms, indicating a legislative shift away from actively supervising the minutiae of HMO practices.[25]

Moreover, the issue here is not the ability of HMOs to enter into such agreements, but whether defendants illegally manipulated the rates specified in their agreements with plaintiffs.[26] Defendants would be hard pressed to argue that the state actively supervises the "downcoding" and "bundling" of claims, among other practices that are alleged by plaintiffs. For these reasons, we reject defendants' state-action-immunity argument.

RICO Claims

Defendants contend that plaintiffs' RICO claims are deficient and incapable of surviving the motion to dismiss. Specifically, defendants argue that plaintiffs (1) failed to articulate any viable predicate acts of fraud, extortion, or bribery; (2) lack standing; (3) failed to identify a viable RICO enterprise; and (4) have not adequately pled critical elements of

[24] Act of December 29, 1972, P.L. 1701, No. 364, § 8, as amended, 40 P.S. § 1558.

[25] The Act of Dec. 18, 1996, P.L. 1066, No. 159, § 14(b), repeals in part 40 P.S. § 1560(c) insofar as subsection (c) provides for the approval of rates and forms by the Insurance Commissioner of the Commonwealth of Pennsylvania. See note following 40 P.S. § 1560.

[26] Act of December 29, 1972, P.L. 1701, No. 364, §§ 8-10, as amended, 40 P.S. §§ 1558-1560.

the specific RICO claims. For the following reasons, we grant in part and deny in part defendants' motion to dismiss plaintiffs' RICO claims.

The Court of Appeals for the Third Circuit has explained the statutory framework for asserting civil RICO claims:

> The RICO statute authorizes civil suits by "[a]ny person injured in his business or property by reason of a violation of [18 U.S.C. § 1962]." 18 U.S.C. § 1964(c) (1988). Section 1962 contains four separate subsections, each addressing a different problem. Section 1962(a) prohibits "any person who has received any income derived . . . from a pattern of racketeering activity" from using that money to acquire, establish or operate any enterprise that affects interstate commerce. Section 1962(b) prohibits any person from acquiring or maintaining an interest in, or controlling any such enterprise "through a pattern of racketeering activity." Section 1962(c) prohibits any person employed by or associated with an enterprise affecting interstate commerce from "conduct[ing] or participat[ing] . . . in the conduct of such enterprise's affairs through a pattern of racketeering activity." Finally, section 1962(d) prohibits any person from "conspir[ing] to violate any of the provisions of subsections (a), (b), or (c)."

Kehr Packages, Inc. v. Fidelcor, Inc., 926 F.2d 1406, 1411 (3d Cir. 1991). In this case, plaintiffs allege violations of 18 U.S.C. § 1962(a), (c), and (d).

Predicate Acts

Defendants assert that all of plaintiffs' RICO claims under 18 U.S.C. §1962 fail because they did not plead sufficient facts to support the elements of at least two predicate acts as required by the statute. Each subsection of 18 U.S.C. §1962 requires the existence of a "pattern of racketeering activity." The statute defines a "pattern of racketeering activity" as requiring the commission of at least two predicate offenses listed in 18 U.S.C. §1961(1).[27] See Kehr Packages, 926 F.2d at 1412, citing 18 U.S.C. §1962(5). Here, plaintiffs allege that the defendants violated the following sections of Title 18 of the United States Code: § 1341 (mail fraud); § 1343 (wire fraud); § 1951(b)(2) (extortion under the Hobbs Act); § 1952(a) (Travel Act); and § 1954 (bribery).

Mail and Wire Fraud[28]

Defendants contend that plaintiff failed to allege any

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[27] The relevant portions of 18 U.S.C. § 1961(1) provide: "racketeering activity" means any act which is indictable under any of the following provisions of Title 18, United States Code: Section 1341 (relating to mail fraud); Section 1343 (relating to wire fraud); Section 1951 (relating to interference with commerce, robbery, or extortion); Section 1952 (relating to racketeering enterprises involving interstate travel or transportation); and Section 1954 (relating to unlawful employee benefit plan payments, bribes or kickbacks).

[28] Because the plaintiff's mail and wire fraud claims are almost identical factually, we consider them concurrently. "As we have noted, the wire fraud and mail fraud statutes differ only in form, not in substance, and cases . . . interpreting one govern the other as well.". See United States v. Morelli, 169 F.3d 798, 806 n.9 (3d Cir. 1999).

viable claim for fraud. To prove mail or wire fraud, the plaintiff must demonstrate (1) the defendants' knowing and willful participation in a scheme or artifice to defraud, (2) with the specific intent to defraud, and (3) the use of the mails or interstate wire communications in furtherance of the scheme. United States v. Antico, 275 F.3d 245, 261 (3d Cir. 2001).

Although the mail or wire communication must relate to the underlying fraudulent scheme, it need not contain any misrepresentations. Mail fraud occurs so long as the mailing is "incident to an essential part of the scheme". See Schmuck v. United States, 489 U.S. 705, 712, 109 S.Ct. 1443, 1448, 103 L.Ed.2d 734, 744 (1989). Moreover, the scheme or artifice to defraud need not be fraudulent on its face, but must involve some sort of fraudulent misrepresentations or omissions[29] reasonably

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[29] Defendants argue that plaintiffs' mail and wire fraud claims based solely on omissions must fail, contending that the Third Circuit Court of Appeals has recognized that non-disclosure cannot form the basis of a fraud claim absent a special relationship between the parties. See Kehr Packages, 926 F.2d at 1416. There the Third Circuit stated: "Since Donnelly never represented that he had lending authority, or that the funds would be provided, his non-disclosure cannot reasonably said to be deceptive." In Kehr Packages, the Third Circuit relied upon the Second Circuit decision in United States v. Von Barta, 635 F.2d 999, 1006-1007 (2d Cir. 1980), which stated that non-disclosure is not actionable under mail fraud statute absent some duty to disclose.

In this case, defendants' blanket assertion is too broad. In Kehr Packages the Third Circuit only recognized that an omission must be deceptive in nature absent a special relationship. See 926 F.2d at 1416. Moreover, the Court explicitly stated: "The scheme need not involve affirmative misrepresentation . . . , but the statutory term 'defraud' usually signifies the deprivation of something of value by trick, deceit, chicane or overreaching." 926 F.2d at 1415 (internal quotations and citations omitted). In addition, in Brokerage Concepts, Inc. v. U.S. Healthcare, Inc., 140 F.3d 494, 528 (3d Cir. 1998), the Third Circuit recognized that omission

calculated to deceive persons of ordinary prudence and comprehension. Kehr Packages, 926 F.2d at 1415. In this case, defendants assert that plaintiff did not successfully allege misrepresentations or omissions.

Keeping in mind that allegations of fraud must be pled with particularity under Federal Rule of Civil Procedure 9(b), we conclude that plaintiffs have alleged some specific misrepresentations and omissions pertaining to their claims of mail and wire fraud sufficient to overcome defendants' motion to dismiss. Others, however, will be dismissed for either lack of

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(Continuation of footnote 29):
need only be "reasonably calculated to deceive" to constitute a "scheme to defraud".

The Court of Appeals for the Seventh Circuit has explained what is required for an omission to constitute fraud, absent a special relationship of fiduciary duty:

> United States v. Keplinger, 776 F.2d 678, 697 (7th Cir. 1985), holds "that omissions or concealment of material information can constitute fraud . . . cognizable under the mail fraud statute, without proof of a duty to disclose the information pursuant to a specific statute or regulation." In that case a laboratory had omitted from a report on the toxicity of a drug an opinion by a consultant that the drug had some toxic effects, and we held that the jury was entitled to find that this omission was fraudulent, given the impression, conveyed by the report, of the utter harmlessness of the drug. Plenty of cases say that "merely failure to disclose" is not, without more, mail fraud, e.g., Reynolds v. East Dyer Development Co., 882 F.2d 1249, 1252 (7th Cir. 1989), and we certainly have no quarrel with this proposition. Whether a failure to disclose is fraudulent depends on context, United States v. Biesiadecki, 933 F.2d 539, 542-43 (7th Cir. 1991) . . . .

Emery v. American General Finance, Inc., 71 F.3d 1343, 1346-1347 (7th Cir. 1995).

In addition, the Tenth Circuit stated in U.S. v. Cochran, 109 F.3d 660, 665 (10th Cir. 1997): "Even apart from a fiduciary duty, in the context of certain transactions, 'a misleading omission is actionable as fraud . . . if it is intended to induce a false belief and resulting action to the advantage of the misleader and the disadvantage of the misled.'".

particularity or failure to state a claim.

The central assertion of plaintiffs' fraud claims is that when contracting with plaintiffs, defendants intentionally misrepresented and failed to disclose internal HMO policies and practices that were designed to systematically reduce, deny, and delay payments to plaintiffs and their business.

There are three components to plaintiffs' fraud claims. First, plaintiffs describe a fraudulent monthly transmission by defendants of a "Primary Capitation/Eligibility Statement" ("monthly statement") that details capitation payments to plaintiffs. Second, plaintiffs describe five fraudulent omissions in a similar quarterly transmission, called a "Full Service Bonus Capitation Report" (the "quarterly report"), which details points awarded to providers under a program offering financial rewards for maintaining organizational standards sought by the HMO. Third, plaintiffs describe thirteen fraudulent omissions and misrepresentations made generally by defendants in the course of various mailings.

The Monthly Statements

Plaintiff begins by claiming that the monthly statements constitute predicate acts of fraud. (RICO Case Statement at 4; Complaint at ¶¶ 57, 89). Plaintiffs contend that the monthly statements misrepresented the amount of money to

which plaintiffs were entitled because they undercounted the number of members actually enrolled in plaintiffs' medical practice and that the HMO-physician agreement purposefully misrepresented how the monthly capitation would be assigned:

> Defendants refuse to begin paying capitation immediately upon enrollment of the members. They retain premiums from the members until the members need services from physicians. The failure to assign immediately not only defrauds doctors, but also undermines the actuarial assumptions on which capitated arrangements are purportedly based. The rationale of capitation is that the doctor services a group of patients, only some of which need services in a given month. The capitated payments for the "well" members is needed to help to compensate for the services provided to the "sick" members. If there are not enough well members, then the doctors provide more services than the capitated payments will support. Defendants' delayed assignment of the members until they are sick, clearly is intended to shave monies that they know doctors need to meet their care obligations.

Complaint at ¶¶ 55(d).

Defendants attempt to defend against this allegation by noting that the capitation rates were affirmatively disclosed in the HMO-physician agreement.[30] Disclosure of the capitation

[30] Defendants note that generally a court ruling on a motion to dismiss may only consider the pleadings in deciding the motion, a document specifically relied upon in the complaint may be examined without converting the motion to dismiss into one for summary judgment. See In Re: Burlington Coat Factory Securities Litigation, 114 F.3d 1410, 1426 (3d Cir. 1997). Defendants have therefore attached a copy of the HMO-physician agreement, signed by plaintiff in December of 1998, and a 2001 copy of the Keystone Health Plan Central Administrative Manual referenced in the agreement for our consideration.

rates, however, is irrelevant with regard to plaintiff's allegation that the HMO-physician agreement misrepresented when capitations would be paid for enrolled members or that the monthly statements affirmatively misrepresented the number of enrolled members.

Moreover, reference to the language of the HMO-physician agreement appears to support plaintiffs allegations. The HMO-physician agreement provides in-part:

> KHPC agrees to compensate Primary Care Physician at the monthly rates listed below for each Member[31] who selects Primary Care Physician. For Members who have elected a benefit Program with Primary Care Physician office and home visit co-payments, the primary care capitation rates have been adjusted accordingly.
>
> The total monthly payment will represent the sum of the number of members within each age and sex group and co-payment arrangement times the specified capitation rate for that

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(Continuation of footnote 30):
Although we concur that we may consider the copy of the signed agreement, we do not believe that we can consider the attached edition of the manual because it was published over two years after the parties entered into the agreement. "[A] court may consider an undisputedly authentic document that a defendant attaches as an exhibit to a motion to dismiss if the plaintiff's claims are based on the document." In Re: Donald J. Trump Casino Securities Litigation-Taj Mahal Litigation, 7 F.3d 357, 368 n.9 (3d Cir. 1993). Because in this case we have no way of knowing that the subsequently published edition of the manual accurately reflects the terms of the 1998 agreement alleged to contain the relevant misrepresentations and omissions, we decline to consider the 2001 edition of the manual provided by defendant.

[31] The HMO-physician agreement defines a "Member" as "an individual who has entered into a contract with KHP Central (or on whose behalf a contract has been entered into) for the provision of medical and hospital services, and the eligible dependants of such individual, who have selected or been assigned to Primary Care Physician."

> age group and co-payment arrangement. KHPC will adjust the number of Members on a monthly basis to reflect changes in enrollment of Members in Primary Care Physician's practice in accordance with KHPC enrollment procedures. A listing of eligible Members will be transmitted to Primary Care Physician at the beginning of each month.
>
> Capitation payment will be paid to Primary Care Physician on the fifth of each month.

The language of the agreement clearly indicates that primary care physicians would be paid monthly for all enrolled patients and that the number of patients enrolled would be updated monthly. Therefore, plaintiffs' allegations pertaining to "shaving" patients from the monthly statements allege predicate acts of fraud.

The Quarterly Reports

Plaintiffs next allege that defendants used their quarterly reports[32] to further a scheme by which defendants defrauded plaintiffs of bonuses promised in the HMO-physician agreement.[33] Specifically, plaintiffs claim that defendants

[32] According to plaintiffs, defendants use criteria in these statements to evaluate and award bonus payments to physicians to offset the administrative costs of processing claims as directed by defendants. (Complaint at ¶ 43).

[33] Attachment C of the HMO-physician agreement provides that quarterly Full Service Bonus Capitation (FSBC) is "the product of Member Months for the respective quarter (MM), the current Reward Ratio (RR) and 3.1 [FSBC = MM x RR x 3.1]".

Attachment B explains how the Reward Ratio is calculated:

concealed the following material facts with respect to the bonuses earned by plaintiffs: (1) plaintiffs are penalized for maintaining the health of members instead of allowing them to become seriously ill by deducting "reward" points for services provided to patients that are not sufficiently "ill"; (2) an "Efficiency Index" which comprises 20% of the points available for calculating the reward is unattainable, and also double-counts deductions that are calculated in another category; (3) reward points are based on member satisfaction surveys and complaint rates that depend upon statistically insignificant

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(Continuation of footnote 33):

> Primary Care Physician's eligibility and participation in the Full Service Bonus Capitation will be determined based in part on a Reward Ratio calculated for each Primary Care Physician practice as follows:
>
> The Reward Ratio will be calculated by dividing the total number of Reward Points awarded to the Primary Care Physician practice by KHP Central in each of three categories: a) Quality Assurance, b) Morbidity Index and c) Efficiency; by the total number of points possible.
>
> The Quality Assurance ratings are based on KHP Central's most recent Quality Assurance Review of the Primary Care Physician practice as well as several member satisfaction factors. The factors defining the Quality Assurance rating are: a chart review including preventive health criteria and quality of medical record documentation; a site visit determination of the office environment, and the scope of services provided by the Primary Care Physician. The member satisfaction rating are based on the transfer rate of members to a different KHPC Primary Care Physician practice, the complaint rate per 1000 members and the results of the member satisfaction survey.
>
> The Morbidity Index is based on the severity of illness of the population within the Primary Care Physician's practice. This measure is calculated using the Codman Research software.
>
> The Efficiency Index is based on the utilization of resources, adjusted for the severity of illness of the practice population. This measure is also calculated using the Codman Research software.

sampling; (4) rewards based on "Medical Record Documentation" are based on random and varying criteria which are unrelated to covered services provided by the physicians; and (5) if providers request a review of rewards or contest results, overall "Points Earned" are reduced as a penalty at the next evaluation period. (RICO Case Statement at 4(b); Complaint at ¶ 90).

Defendants respond that these omissions cannot be construed as "reasonably calculated to deceive persons of ordinary prudence and comprehension." Kehr Packages, 926 F.2d at 1415. In addition, defendants contend the conditions for awarding quarterly bonuses were clearly established in the HMO-physician agreement. Although most of plaintiffs' claims pertaining to the quarterly reports are sufficient to overcome the motion to dismiss, we conclude defendants are correct in at least one instance.

Plaintiffs' allegation of statistically insignificant sampling does not state a claim for fraud because the clear language of the agreement revealed that such a sampling would not occur. See Ideal Dairy Farms, Inc. v. John Labatt, Ltd., 90 F.3d 737, 747 (3d Cir. 1996). Here, the agreement expressly provided: "The member satisfaction ratings are based on the transfer rate of members to a different KHPC Primary Care Physician practice, the complaint rate per 1000 members and the results of the member satisfaction survey." Although there is

some ambiguity as to the number of satisfaction surveys issued or returned, we conclude there is no misleading information in the agreement that a statistical sampling would occur or even be feasible in the patient population of single practice. Therefore, we grant defendants' motion to dismiss this claim of fraud.

Plaintiffs' remaining allegations pertaining to the quarterly bonuses constitute valid claims for fraud. The bonuses promised within the agreement are a "reward" to physicians who provide quality and efficient services to their patients. However, an obvious purpose of promising increased monetary rewards is to induce physicians to enter into the agreement.

Here, plaintiffs contend that the agreement's omissions effectively make the promised "rewards" unattainable by (1) penalizing early treatment of patients; (2) providing a unattainable efficiency standards and double deducting reward points; (3) providing random and varying criteria for medical record documentation; and (4) taking reward points from physicians who question the accuracy of quarterly reports. The contract discloses none of these practices, and if proven, could deprive the plaintiff of money promised by the contract. Construing all facts and inferences in favor of the plaintiffs, as we are required to do under the standard of review, we conclude that such omissions could have been reasonably

calculated to deceive persons of ordinary prudence and comprehension. See Kehr Packages, 926 F.2d at 1415.

Accordingly, defendants' motion to dismiss regarding these four allegations of fraud is denied.

Additional Omissions and Misrepresentations

Next, we address plaintiffs' allegations that defendants use the wires and mails to send, telecopy and e-mail their written contracts and agreements with plaintiffs, responses to claims, plan materials, payments, and other documents, which fraudulently misrepresent and conceal a host of material facts.

Specifically, plaintiffs allege that defendants (1) misrepresented to plaintiffs that defendants would pay plaintiffs for medically necessary services and procedures according to CPT codes for the services and procedures which plaintiffs provided; (2) concealed that they developed and use guidelines which are based on financial consideration instead of medical necessity; (3) concealed that they systematically deny claims; (4) concealed that they deliberately delay payments; (5) concealed that they provide incentives to claim reviewers to delay or deny payments; (6) concealed developed or purchased claims systems designed to manipulate CPT codes; (7) concealed that they automatically downcode claims; (8) concealed that they automatically bundle claims; (9) concealed that capitation payments do not have a

sound actuarial basis; (10) concealed their use of age/sex adjustment factors to adjust capitation payments below the levels defendants agreed to pay; (11) concealed capitation arrangements under which plaintiffs will be financially responsible for the cost of additional care and treatments such as injectable drugs; and (12) failed to distribute money for participation in risk pools.

We conclude that many of these allegations fail because they are expressly disclosed in the HMO-physician agreement. See Ideal Dairy Farms, 90 F.3d at 747.

Initially, we dismiss the allegation based on defendants' supposed general concealment of developing guidelines based on cost-containment because the HMO-physician agreement clearly states: "KHP Central has [as] an objective the development and expansion of cost-effective means of delivering healthcare services to members . . . . " In addition, the agreement unambiguously provides for varying capitation rates based on a patient's age and sex, and discloses that participating physicians will provide "therapeutic injections" as part of their capitated services.[34] Therefore, we dismiss the

[34] Plaintiffs contend that technology has significantly increased the number of capitated injectable drugs that they are expected to provide, such that the cost far surpasses yearly capitation rates for some patient populations. Such an increase appears to be a factor of scientific progress rather than a misleading omission on the part of the defendants and an issue better suited for future contract negotiations.

two claims based on these "omissions" as well.

In a similar vein, plaintiffs' allegation claiming that defendants have concealed that capitation payments do not have a sound actuarial basis does not amount to fraud because this omission cannot be construed as "reasonably calculated to deceive persons of ordinary prudence and comprehension". Kehr Packages, 926 F.2d at 1415. The HMO-physician agreement clearly provided the applicable capitation rates, and there is nothing in the contract to suggest that these rates would be actuarially sound. Therefore, we dismiss this claim.

We also conclude that two of plaintiffs' allegations do not satisfy the particularity required by Federal Rule of Civil Procedure 9(b). Specifically, we dismiss the following general claims for lack of particularity in pleading: that defendants concealed that they systematically deny claims, and that defendants deliberately delay payments.

We recognize that plaintiffs need not plead the "date, place or time"" of the fraud to fulfill the requirements of Rule9(b), so long as they use an alternative means of injecting precision and some measure of substantiation into their allegations of fraud. See Rolo v. City Investing Co. Liquidating Trust, 155 F.3d 644, 658 (3d Cir. 1998), overruled on other grounds, Forbes v. Eagleson, 228 F.3d 471 (3d Cir. 2000). However, we find these generalized allegations are duplicative of

more specific claims, addressed below, that are sufficiently pled for the purposes of Rule 9(b). Accordingly, we dismiss both claims.

For the following reasons, we conclude plaintiffs' remaining allegations sufficiently state claims for fraud. Initially, plaintiffs allege that defendants misrepresented that defendants would pay plaintiffs for medically necessary services and procedures according to CPT codes for the services and procedure that plaintiffs provided.[35]

The HMO-physician agreement appears to support this claim by providing that plaintiffs would be paid from a reimbursement allowance and by defining this allowance as, "the amount to be paid to Primary Care Physician by KHP Central (and by the Member for authorized co-payments) for medically necessary Covered Services rendered to the Member which are not Primary Care Services as set forth in this Agreement." Depending upon the specific definitions of "Covered Services" and their

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[35] Because we must accept the facts as presented by the plaintiffs, we turn to their RICO Case Statement, which provides a cogent explanation of how the underlying payment system operates:

> Defendants contract with physicians and physicians groups – such as plaintiffs – to provide medical services to their insured members. These physicians and physicians groups . . . receive compensation for their services under two types of payment arrangements: (1) capitation, and (2) fee for services. Under the capitation arrangement, plaintiffs receive monthly "Primary Capitation/Eligibility Statements . . . .

(Plaintiffs' RICO Case Statement at 3-4).

accompanying pay schedules, defendants' failure to comply could constitute fraud.[36]

Similarly, when viewed in conjunction with the agreement's representation that defendants would pay for medically necessary services, the omissions that plaintiffs allege appear to be material and could be construed as "reasonably calculated to deceive persons of ordinary prudence and comprehension." Kehr Packages, 926 F.2d at 1415. Plaintiffs contend that defendants concealed that defendants (1) provide incentives to claim reviewers to delay or deny payments; (2) developed or purchased claims systems designed to manipulate CPT codes; (3) automatically downcode claims; (4) automatically bundle claims; and (5) will not distribute money for participation in risk pools to which plaintiffs claim they are entitled.

We conclude that all of these alleged omissions from the agreement, if proven, could significantly decrease the amount of reimbursements which the contract promised to pay to plaintiffs. Likewise, such non-disclosures could have affected

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[36] Defendants contend that the agreement authorizes them to change the amount to be paid by stating: "It shall determined by KHP Central at the lower of the Primary Care Physician's actual charge, his/her filed fee as filed with KHP Central, or the prevailing fee for the applicable procedure as determined by Pennsylvania Blue Shield, or according to any applicable KHP Central reimbursement schedule."

However, we conclude that this provision is sufficiently broad and ambiguous to leave a question of fact as to what the appropriate payments should have been.

plaintiffs' decision to enter into the HMO-physician agreement. Accordingly, we conclude that plaintiffs have stated claims upon which relief could be granted. Hence, defendants' motion to dismiss is denied regarding these claims.

Extortion

Plaintiffs also allege violations of the Hobbs Act as predicate offenses to their RICO claims. The Hobbs Act provides that whoever affects commerce by extortion shall be fined, imprisoned, or both. 18 U.S.C. § 1951(a). The Hobbs Act defines "extortion" as "the obtaining of property from another, with his consent, induced by wrongful use of actual or threatened force, violence, or fear, or under color of official right." 18 U.S.C. § 1951(b)(2). The Court of Appeals for the Third Circuit has recognized that the term "fear" includes the fear of economic loss, which is what the plaintiffs claim in the present case. See Brokerage Concepts, Inc. v. U.S. Healthcare, Inc., 140 F.3d 494, 522 (3d Cir.1998).

In Brokerage Concepts, U.S. Healthcare refused to grant a small pharmacy membership in its network of medical prescription providers unless the pharmacy agreed to discontinue its contractual relationship with plaintiff, Brokerage Concepts, Inc., a health care consulting firm whose specialty is serving as a Third Party Administrator for health benefit self-insurers.

140 F.3d at 501. U.S. Healthcare would only grant membership to the pharmacy if it gave its administrator business to a U.S. Healthcare subsidiary. Because U.S. Healthcare subscribers constituted a significant portion of its customer base, the pharmacy yielded to the pressure and gave its administrator business to a U.S. Healthcare subsidiary.

Brokerage Concepts sued, asserting Sherman Act anti-trust and civil RICO claims (including one under the Hobbs Act). 140 F.3d at 501-502. The plaintiff won on all claims in a jury trial, and defendants appealed after the district court upheld the jury's verdict. 140 F.3d at 502.

The Court of Appeals reversed on the Hobbs Act claim, recognizing that use of the fear of economic loss is only "wrongful" within the meaning of the statute if the defendant does not have a lawful claim to the money or property he sought through the use of economic fear. 140 F.3d at 524. The Third Circuit found that when a purported victim of extortion receives something of value in exchange for money or property, such a situation merely constitutes "hard bargaining". Specifically, the Third Circuit stated:

> In a "hard bargaining" scenario the alleged victim has no pre-existing right to pursue his business interests free of the fear he is quelling by receiving value in return for transferring property to the defendant, but in an extortion scenario the alleged victim has a preexisting entitlement to pursue his

> business interests free of the fear he is quelling by receiving value in return for transferring property to the defendant.

Brokerage Concepts, supra, quoting Viacom International v. Icahn, 747 F.Supp. 205, 213 (S.D.N.Y. 1990).

Applying this principle to the pharmacy's situation, the Brokerage Concepts Court found that unless Pennsylvania enacted an "Any Willing Provider" law, which compels HMOs to allows all interested and minimally qualified providers into their networks, the pharmacy did not have any pre-existing legal right enter into a contract with U.S. Healthcare.

Defendants claim that Brokerage Concepts controls the present situation. They contend that physicians like Dr. Grider do not have an independent right to practice medicine within Pennsylvania's health care provider networks. We conclude that defendants are correct in this assertion because Pennsylvania does not have an "Any Willing Provider" statute.[37]

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[37] As former Chief Judge Becker pointed out in Brokerage Concepts, Pennsylvania lacks an "Any Willing Provider" statute:

> Indeed, if Pennsylvania had such a law not only might the outcome of this suit, at least as it pertains to the RICO counts, be different, but it is likely that the underlying facts would never have occurred. Those facts, which demonstrate how heavy-handed tactics can be effectively applied by a large corporation (U.S.Healthcare) against a small firm (Gary's) in this context, might suggest to the Pennsylvania General Assembly that it is time to enact an Any Willing Provider law in Pennsylvania.

Brokerage Concepts, 140 F.3d at 526 n.22.

However, we conclude the facts alleged by plaintiffs in this case present a very different situation than the narrow grounds on which Brokerage Concepts was decided. Moreover, we conclude that the Third Circuit intended to limit the holding in Brokerage Concepts when it stated "we deal with a very narrow subset of the potential universe of extortion cases: one involving solely the accusation of the wrongful use of economic fear where two private parties have engaged in a mutually beneficial exchange of property." 140 F.3d at 525-526.

In this case, plaintiffs' Complaint alleges two possible Hobbs Act violations: one stemming from the use of economic fear after the parties entered into the HMO-physician agreement, and another that alleges use of economic fear that predates the formation of the agreement. We conclude that the former states a valid Hobbs Act claim, and the latter does not.

In their first claim, plaintiffs allege that after entering into the HMO-physician's agreement, defendants began to implement a series of underhanded techniques for cheating plaintiffs out of money they were due under the terms of the agreement, such as "shaving" capitation payments, and so forth. Plaintiffs contend that when they questioned defendants' accounting, defendants retaliated by cutting the plaintiffs' efficiency rating in half to decrease plaintiffs' bonuses significantly in the next quarterly review and further decreased

other reimbursements.

This situation differs from the one in Brokerage Concepts because here plaintiffs allege that they had a pre-existing contractual right to the money that was "shaved" from their capitation payments and the bonuses and reimbursements that subsequently were cut. Whereas, in Brokerage Concepts the Third Circuit determined that the pharmacy had no pre-existing right to be member of HMO's network.

In other words, plaintiffs allege that in exchange for not complaining about the capitation "shaving" they would have received bonuses that were already due to them under the HMO-physician contract. We conclude that this may, if proven at trial, constitute extortion under the Hobbs Act. Accordingly, we deny defendants' motion to dismiss this portion of plaintiffs' claim based upon the Hobbs Act.

In contrast, we conclude that plaintiff's second claim does not state a valid Hobbs Act violation. In this claim, plaintiffs aver that defendants exercise such coercive economic power that it is impossible to negotiate (or renegotiate) a fair arms-length contract. Plaintiffs assert that the HMO-physician agreement constitutes an adhesion contract and if they do not accept its terms they fear being shut out of defendants' network and effectively will be unable to practice their profession.

Unfortunately for the plaintiffs, this argument runs afoul of the holding in Brokerage Concepts because they have no pre-existing right to be part of defendants' healthcare network absent an "Any Willing Provider" statute. Brokerage Concepts, supra. Plaintiffs contend that anti-trust laws may confer the necessary protection in lieu of an "Any Willing Provider" statute. See 140 F.3d at 526 n.23.[38] However, plaintiffs have not alleged in their Complaint or RICO case statement that defendants are a monopoly or that they violated antitrust laws. Absent such allegations, we grant defendants' motion to dismiss their second Hobbs Act claim.

Bribery

Plaintiffs allege bribery in connection with an employee benefit plan under 18 U.S.C. § 1954 as a predicate act to their RICO claims. Section 1954 provides in pertinent part:

> Whoever being-
>
> (1) an administrator, officer, trustee, custodian, counsel, agent, or employee of any

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[38] In a footnote in Brokerage Concepts, the Third Circuit alluded to the possible use of antitrust laws:

> This is also not a case where U.S. Healthcare exerted monopoly power in the market for pharmaceutical customers. Under such circumstances, the antitrust laws might well confer on Gary's the legal right to be free of the economic coercion arising from U.S. Healthcare's monopoly. However, we are not presented with such a case and thus do not opine on the potential success of such a theory.

Brokerage Trust, 140 F.3d at 526 n.23.

> employee welfare benefit plan or employee pension benefit plan; or
>
> (2) an officer, counsel, agent, or employee of an employer or an employer any of whose employees are covered by such plan; or
>
> (3) an officer, counsel, agent, or employee of an employee organization any of whose members are covered by such plan; or
>
> (4) a person who, or an officer, counsel, agent, or employee of an organization which, provides benefit plan services to such plan
>
> receives or agrees to receive or solicits any fee, kickback, commission, gift, loan, money, or thing of value because of or with intent to be influenced with respect to, any of the actions, decisions, or other duties relating to any question or matter concerning such plan or any person who directly or indirectly gives or offers, or promises to give or offer, any fee, kickback, commission, gift, loan, money, or thing of value prohibited by this section, shall be fined under this title or imprisoned not more than three years, or both: Provided, That this section shall not prohibit the payment to or acceptance by any person of bona fide salary, compensation, or other payments made for goods or facilities actually furnished or for services actually performed in the regular course of his duties as such person, administrator, officer, trustee, custodian, counsel, agent, or employee of such plan, employer, employee organization, or organization providing benefit plan services to such plan.

Plaintiffs assert that defendants improperly provide direct cash bonuses and other benefits as rewards to claim reviewers based on a percentage of claims wrongfully delayed or denied, regardless of whether treatments were medically necessary. As a result, plaintiffs claim that their business has been injured by the

delay or denial of compensation due under the HMO-physician agreement.

Defendants cite Shearin v. E.F. Hutton Group, Inc., 885 F.2d 1162, 1167-1168 (3d Cir. 1989), overruled on other grounds, Beck v. Prupis, 529 U.S. 494, 120 S.Ct. 1608, 146 L.Ed.2d 561 (2000) for the proposition that plaintiffs have failed to establish the required nexus between the alleged statutory violation and a concrete financial loss because plaintiff's injury must be caused by predicate act. Defendants contend that nowhere in the Complaint does Dr. Grider identify a single reimbursement denial or delay that she claims was caused by the payment of an 'incentive' to a claims reviewer. Hence, defendants contend that plaintiffs have not pled a predicate act. For the following reasons, we disagree.

Despite defendants' objection, plaintiffs have successfully alleged a claim for bribery under 18 U.S.C. § 1954. The nexus between the claimed statutory violation and plaintiffs' harm could not have been more clearly alleged. Plaintiffs aver that they were wrongfully denied payment of compensation due under the HMO-physician agreement because defendants bribed claim reviewers with illegal bonuses and kickbacks. Although plaintiffs do not cite to individualized claim denials on specific dates for particular sums, such specificity is not required under the Federal Rules' liberal standard for notice

pleading. See Fed. R. Civ. P. 8(a).[39]

Travel Act

For the reasons expressed below, we conclude that plaintiffs have properly pled a Travel Act violation as a predicate offense to their RICO claim. The Travel Act, 18 U.S.C. § 1952, establishes criminal liability for one who travels in interstate commerce or uses the mail system, with intent to "promote, manage, establish, carry on, or facilitate the promotion, management, establishment, or carrying on, of any unlawful activity." Managed Care, 135 F.Supp.2d at 1265 quoting 18 U.S.C. § 1952.

Plaintiffs aver that "the Defendants on numerous occasions did travel in interstate commerce in an attempt to and to commit extortion in violation of the Travel Act, 18 U.S.C. § 1954(a)." (Complaint at ¶ 103). Moreover, because we have already concluded that one of the plaintiffs' alleged predicate acts of extortion has survived defendants' motion to dismiss, we conclude that plaintiffs' Travel Act claim also survives. Accordingly, defendants' motion to dismiss plaintiffs' Travel Act claim is denied.

[39] In their reply to plaintiffs' opposition to the motion to dismiss, defendants briefly suggest that plaintiffs have taken inconsistent positions as to whether ERISA preempts a claim for damages based on alleged delays in making payments and therefore the bribery claim should be dismissed. Defendants, however, do not fully explain their argument and cite no caselaw for support. Therefore, we do not consider it.

RICO Standing

Defendants contend that, under the Third Circuit's decision in Maio v. Aetna, 221 F.3d 472 (3d Cir. 2000), plaintiffs lack standing to bring their RICO claims because they have not alleged a breach of contractual terms.

Plaintiffs have standing to sue under RICO if they have suffered injury to their "business or property by reason of a violation of section 1962." 18 U.S.C. § 1964(c). To pass RICO muster, a plaintiff must include "a showing that the plaintiff's injury was proximately caused by the alleged RICO violation." In addition, "a showing of injury requires proof of a concrete financial loss and not mere injury to a valuable intangible property interest." Maio, 221 F.3d at 483.

In Maio, subscribers in Aetna HMO plans claimed that Aetna fraudulently induced them to enter into HMO plans and then provided service of a lesser quality than they had been led to expect. Plaintiffs asserted that the difference between what they paid and the actual worth of the services constituted a financial loss for RICO purposes. 221 F.3d at 486-487. Plaintiffs did not, however, allege any injury stemming from a breach of their membership contracts with Aetna, or from denial of medically necessary benefits.

The Third Circuit found plaintiffs' injury theory

insufficient to support a RICO claim because their interest was not tangible, such as an interest in a parcel of real estate or a diamond necklace. Rather, their interest was a contract right, which could not be diminished in value absent a breach of the contractual terms. In such a context, the Court wrote, an injury could be shown by receipt of "inadequate, delayed or inferior care, personal injuries resulting therefrom, or Aetna's denial of benefits due under the insurance arrangement." 221 F.3d at 490.

Another problem faced by the plaintiffs in Maio flowed from the additional layer of responsibility between them and Aetna (the participating doctors and hospitals who actually provided the health care to members). Plaintiffs could not prevail because it was impossible for them to prove that Aetna's policies were the cause of their injury unless they could show that those policies "actually negatively affected the health care that Aetna provided to its HMO members through its participating providers." 221 F.3d at 491. In Maio plaintiffs were not able to make such a showing.

Upon review of plaintiffs' Complaint and RICO Case Statement, we conclude that several factors distinguish Maio from the instant case. As providers, plaintiffs here allege an injury to their business, rather than solely to a property interest

arising from a contractual right.[40] Plaintiffs have alleged a concrete financial loss rather than a speculative diminution in expected value. (RICO Case Statement at 16-17).

While plaintiffs do not allege a specific dollar amount (and, indeed, seek injunctive relief because they claim the losses are continuing), it is unlikely that they could do so without discovery. In addition, in this case, there is no middle layer of responsibility between providers and HMOs, as was the case in Maio, which prevents a showing of proximate cause. Rather, plaintiffs allege that defendants' acts not only directly impact them, but are directed toward them.

In sum, we conclude that plaintiffs have sufficiently pled a concrete financial loss to their business or property and have standing to sue under RICO. Plaintiffs do not aver any specific amount of such loss, other than that they have lost "millions." The liberal pleading requirements of the Federal Rules of Civil Procedure do not require plaintiffs to allege specific figures without discovery regarding how defendants have reduced, denied or delayed payments.

Accordingly, we deny defendants' motion to dismiss plaintiffs' Complaint on the basis of a lack of standing to sue under RICO.

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[40] See Complaint at ¶¶ 39, 48, 55, 56, 65, 84, 85, 95, 100, 101, 104, 105, 112, 132, 135, 143, 147, 151; RICO Case Statement at 7-8, 16-17.

RICO Enterprise

Plaintiffs describe an enterprise that includes defendants and various third-party entities, including software providers, claims reviewers, and trade associations. Plaintiffs contend that defendants conduct the enterprise by using these third-parties to deny, delay and reduce payments to providers, employing a variety of techniques that are undisclosed and do not conform to plaintiffs' definition of "medically necessary."

Section 1961(4) of the RICO Act defines "enterprise" as including "any individual, partnership, corporation, association, or other legal entity, and any union or group of individuals associated in fact although not a legal entity." 18 U.S.C. § 1961(4). Defendants argue that plaintiffs have not pleaded a RICO enterprise or its structure with sufficient detail, citing two unpublished cases in this District: Gaynor v. Nelowet, 2000 WL 427274 (E.D. Pa. April 19, 2000) (Ludwig, J.); and Cohen v. Daddona, 1996 WL 571754 (E.D. Pa. September 30, 1996) (Rendell, J.); and the Seventh Circuit's decision in Richmond v. Nationwide Cassel L.P., 52 F.3d 640, 643 (7th Cir. 1995) for the proposition that where a complaint merely lists a string of entities without further elaboration, the enterprise element of the RICO claim has not been established.

Each of the cases cited by defendants, however,

involved a complaint that clearly could not satisfy the requirements of notice pleading. In Cohen, there were over 40 defendants and an "unusual and confusing" fact pattern that required greater specificity in order to put each defendant on notice as to what exactly was alleged. Cohen, 1996 WL 571754 at *2.

Gaynor also involved a singularly deficient complaint, "present[ing] an assortment of individuals" as the enterprise with no allegations that the individuals constituted a continuing enterprise or that the enterprise had any common purpose other than to "rob" plaintiff. Gaynor involved a plaintiff who sued his family members, his and their lawyers and various judges and judicial officers for conspiring to steal money from him in an estate proceeding.

Finally, Richmond involved a plaintiff who simply named a string of entities without any elaboration as to their association or structure: "Not one of the non-defendant entities, supposedly constituent parts of the 'enterprise,' is described as playing a role in [the alleged illegal activity] . . . . This complaint clearly alleges only that the defendants perpetrating the fraud . . . were conducting their own (and each other's) affairs." Richmond, 52 F.3d at 645-646.

While the Complaint here does list a number of unnamed third parties as being part of the enterprise, the later-filed

RICO Case Statement provides a named list of entities that make up the alleged Managed Care Enterprise. (Complaint at ¶ 70; RICO Case Statement at 13). Plaintiffs then describe how defendants allegedly use nonparty firms to further the RICO violations, employing such devices as "common billing forms, a 'technology alliance' and 'central coordination' to accomplish their systematic scheme to deny, delay and diminish payments to plaintiffs." (RICO Case Statement at 10).

Defendants cite several cases holding that ordinary business relationships or contractual relationships do not suffice for enterprise allegations, but plaintiffs allege that the relationships between the defendants and the other entities that make up the enterprise go beyond ordinary business dealings. While greater specificity with respect to structure and the interrelationship between the portions of the alleged enterprise would no doubt be desirable, it is uncertain as to how plaintiffs could accomplish this without discovery.

Moreover, unlike the fraud allegations already discussed, there is no heightened pleading standard for allegations of RICO enterprise, as defendants concede. "At the pleading stage, a plaintiff typically need only identify the alleged enterprise to satisfy notice pleading requirements." Seville Industrial Machinery Corp. v. Southmost Machinery Corp., 742 F.2d 786, 790 (3d Cir. 1984). Plaintiffs here have

identified the parties that make up the enterprise (RICO Case Statement at 13-14), described how these parties may be associated (through financial incentives, for example, RICO Case Statement at 6, 9); and alleged in sufficient detail for notice pleading that the entities form a continuing unit with a common course of conduct.

Accordingly, we conclude that plaintiffs have set forth a valid claim upon which relief can be given. Thus, we deny defendants' motion to dismiss on this point.

Elements of Specific RICO Claims

In addition to defects in plaintiffs' enterprise and predicate act allegations, defendants assert that plaintiffs failed to plead the necessary elements of the specific racketeering claims set forth in the Complaint.

Investment of Racketeering Proceeds Under § 1962(a)

Defendants contend that plaintiffs fail to identify any distinct injury flowing from the investment of the proceeds of defendants' alleged misconduct as required by § 1962(a).[41]

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[41] 18 U.S.C. § 1962(a) provides in part:

> It shall be unlawful for any person who has received any income derived, directly or indirectly, from a pattern of racketeering activity or through collection of an unlawful debt in which such person has participated as a principal within the meaning of section 2, title 18, United States Code, to use or

"Under § 1962(a), a plaintiff must allege injury specifically from the use or investment of income in the named enterprise." Kehr Packages, 926 F.2d at 1411 citing Rose v. Bartle, 871 F.2d 331, 357-358 (3d Cir. 1989).

For the following reasons, we conclude defendants are correct in asserting that plaintiffs have failed to allege a claim under Section 1962(a). With regard to injury under § 1962(a), the Complaint provides: "Through the patterns of racketeering alleged above, Defendants have received income which they have used to acquire an interest in, establish and/or operated [sic] the Managed Care Enterprise." (Complaint at ¶ 117). At most, this allegation seems to imply that plaintiffs were injured by subsequent predicate acts made possible through the reinvestment of the original ill-gotten income back into the Managed Care Enterprise.

The Court of Appeals for the Third Circuit has recognized that such allegations are insufficient under Section 1962(a) as a matter of law:

(Continuation of footnote 41):

> invest, directly or indirectly, any part of such income, or the proceeds of such income, in acquisition of any interest in, or the establishment or operation of, any enterprise which is engaged in, or the activities of which affect, interstate or foreign commerce.

> [I]n Brittingham v. Mobil Corp., 943 F.2d at 304-05, we affirmed the district court's dismissal of section 1962(a) claims by consumers who bought garbage bags based on misrepresentations that they were biodegradable. The complaint claimed injury from the use or investment of racketeering income because the money derived from the sale of the garbage bags permitted the enterprise to continue its operations. We held that such an allegation did not state an injury cognizable under section 1962(a); rather it merely alleged the same injury caused by the pattern of racketeering. In so holding, we stated that if the mere reinvestment of racketeering income were to suffice [as an injury under section 1962(a)], the use-or-investment injury requirement would be almost completely eviscerated when the alleged pattern of racketeering is committed on behalf of a corporation. RICO's pattern requirement generally requires long-term continuing criminal conduct. See H.J. Inc. v. Northwestern Bell Telephone Co., 492 U.S. 229, 109 S.Ct. 2893, 106 L.Ed.2d 195 (1989). Over the long term, corporations generally reinvest their profits regardless of the source. Consequently, almost every racketeering act by a corporation will have some connection to the proceeds of a previous act. Section 1962(c) is the proper avenue to redress injuries caused by the racketeering acts themselves. If plaintiffs' reinvestment injury concept were accepted, almost every pattern of racketeering by a corporation would be actionable under § 1962(a) and § 1962(c) would become meaningless. 943 F.2d at 305.

Lightning Lube, Inc. v. Witco Corporation, 4 F.3d 1153, 1189 (3d Cir. 1993). Accordingly, we dismiss plaintiffs' RICO claims based on Section 1962(a) and grant plaintiffs leave to amend their Complaint.

Direction and Control of the Managed Care Enterprise Under § 1962(c)

Defendants contend that plaintiffs have failed to adequately plead that defendants directed and controlled the managed care enterprise as required by 18 U.S.C. § 1962(c). Section 1962(c) provides:

> It shall be unlawful for any person employed by or associated with any enterprise engaged in, or the activities of which affect, interstate or foreign commerce, to conduct or participate, directly or indirectly, in the conduct of such enterprise's affairs through a pattern of racketeering activity or collection of unlawful debt.

The Supreme Court of the United States has explained that "'to conduct or participate, directly or indirectly, in the conduct of such enterprise's affairs,' § 1962(c), one must participate in the operation or management of the enterprise itself." Reves v. Ernst & Young, 507 U.S. 170, 185, 113 S.Ct. 1163, 1174, 122 L.Ed.2d 525, 540 (1993). The Reves Court determined that an accounting firm that failed to disclose to the board of directors of its client, a farming cooperative, that the co-op was insolvent could not be sued under §1962(c) because the accounting firm was not engaged in the management of the co-op's affairs. 507 U.S. at 186, 113 S.Ct. at 1174, 122 L.Ed.2d at 541.

The Court reasoned in part that the accounting firm

constituted an "outsider" to the enterprise and that "§ 1962(c) cannot be interpreted to reach complete 'outsiders' because liability depends on showing that the defendants participated in the conduct of the 'enterprise's affairs,' not just their own affairs."[42] 507 U.S. at 186, 113 S.Ct. at 1173, 122 L.Ed.2d at 540 (emphasis in original). The Court concluded that drafting of the company's financial statements did not constitute management of the co-op's affairs. 507 U.S. at 186, 113 S.Ct. at 1174, 122 L.Ed.2d at 541.

The Court of Appeals for the Third Circuit made a similar determination in University of Maryland v. Peat, Marwick, Main & Company, 996 F.2d 1534 (3d Cir. 1993). There, policy-holders of an insolvent insurer sued an accounting firm under Section 1962(c) for performing a materially deficient audit on the insurer. 996 F.2d at 1536. The Third Circuit held that there must be a "nexus" between the defendant and conducting the affairs of the enterprise. The Court concluded that financial services provided to the insurer, like audits, do not constitute direction of an enterprises affairs. 996 F.2d at 1539.

In this case, plaintiffs have adequately alleged a nexus between the defendants and management of the enterprise.

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[42] The Reves Court, however, recognized that an "outsider" could be liable under § 1962(c), provided that they are "associated" with the enterprise and "participate in the conduct of its affairs . . . . " Reves, 507 U.S. at 185, 113 S.Ct. at 1173, 122 L.Ed.2d at 540 (emphasis in original).

Plaintiffs' Complaint explicitly avers that "[d]efendants maintain an interest in and control of the Managed Care Enterprise and also conduct or participate in the conduct of the Enterprise's affairs through a pattern of racketeering activity." (Complaint at ¶ 72).

Although defendants complain that plaintiffs failed to plead specific facts to link individual defendants to management of the enterprise, the cases that defendants cite and Federal Rule of Civil Procedure 8(a) do not require such specificity. The primary purpose of Rule 8 is to give the defendant fair notice of the claim asserted. Richmond v. Nationwide Cassel L.P., 52 F.3d 640, 645 (7th Cir. 1995).

Moreover, in their motion to dismiss, defendants do not attempt to differentiate between themselves or assert that some among their number are non-managerial "outsiders" to the alleged enterprise. Rather, defendants generally claim that plaintiffs failed to allege a nexus. We conclude that plaintiffs have alleged a sufficient nexus between defendants and management of the enterprise. Therefore, we deny defendants' motion to dismiss with respect to plaintiff's §1962(c) claims.

Conspiracy Under § 1962(d)

Defendants contend that plaintiffs fail to allege any facts to support their claim that defendants formed a conspiracy

under 18 U.S.C. § 1962(d) by an unlawful agreement. "Although detail is unnecessary, the plaintiffs must plead the facts constituting the conspiracy, its object and accomplishment." Commmonwealth of Pennsylvania ex rel. Zimmerman v. PepsiCo, Inc., 836 F.2d 173, 182 (3d Cir. 1988).

To plead conspiracy adequately, "[t]he allegations must be sufficient to 'describe the general composition of the conspiracy, some or all of its broad objectives, and the defendant's general role in the that conspiracy.'" Rose, 871 F.2d at 366, quoting Alfaro v. E.F. Hutton & Co., Inc., 606 F.Supp. 1100, 1117-1118 (E.D. Pa. 1985). However, the particularity requirements of Rule 9 do not apply to civil conspiracy claims. See Rose, 871 F.2d at 336.

Moreover, the Supreme Court has described "conspiracy" in broad terms:

> A conspirator must intend to further an endeavor which, if completed, would satisfy all of the elements of a substantive criminal offense, but it suffices that he adopt the goal of furthering or facilitating the criminal endeavor. He may do so in any number of ways short of agreeing to undertake all of the acts necessary for the crime's completion. One can be a conspirator by agreeing to facilitate only some of the acts leading to the substantive offense.

Salinas v. United States, 522 U.S. 52, 65, 118 S.Ct. 469, 477, 139 L.Ed.2d 352, 367 (1997).

Here, we conclude that plaintiffs have sufficiently alleged a conspiracy. Contrary to the defendants' assertion, plaintiffs have alleged an agreement to violate Section 1962. Plaintiffs' Complaint explicitly avers that "[e]ach defendant, with knowledge and intent, agreed to the overall objective of the conspiracy and each defendant agreed to commit at least two predicate acts and each Defendant agreed to participate in the conspiracy." (Complaint at ¶ 60). Moreover, Plaintiffs' Complaint continues by explaining in great detail the various actions that the named defendants undertook to implement a conspiracy to delay and deny payments due. (Complaint at ¶¶ 58-65, 121-147).

Therefore, because we conclude that plaintiffs have sufficiently pled a cause of action, we deny defendants' motion to dismiss plaintiffs' Section 1962(d) conspiracy claim.

Aiding and Abetting Under RICO

Defendants assert that plaintiffs' claims for aiding and abetting RICO violations must be dismissed. Defendants are correct because the Court of the Appeals for the Third Circuit has expressly rejected all claims for aiding and abetting under RICO:

> In Rolo v. City Investing Co. Liquidating Trust, 155 F.3d 644 (3d Cir.1998), we extended the Supreme Court's reasoning in

> Central Bank of Denver v. First Interstate Bank of Denver, 511 U.S. 164, 114 S.Ct. 1439, 128 L.Ed.2d 119 (1994), to RICO, and held that, because RICO's statutory text does not provide for a private cause of action for aiding and abetting and 18 U.S.C. § 2 cannot be used to imply this private right, no such cause of action exists under RICO. Appellant argues that our holding in Rolo leaves open the possibility that a civil aiding and abetting RICO claim could be recognized as a common law civil remedy. We disagree, and hold that Rolo's holding extends as well to common law-based RICO civil aiding and abetting claims.

Pennsylvania Association of Edwards Heirs v. Rightenour, 235 F.3d 839, 840 (3d Cir. 2000). Accordingly, because it is clear that the Third Circuit has foreclosed plaintiffs' claims for aiding and abetting under RICO, we grant defendants' motion to dismiss.

State Claims

Plaintiffs plead two state law claims against defendants. The first claim asserts that plaintiffs have violated the prompt payment of claims provision of Pennsylvania's Health Care Act. The second claim avers that defendants breached an implied duty of good faith and fair dealing. However, the Supreme Court of Pennsylvania has not specifically addressed whether a private remedy exists under Pennsylvania's Health Care Act or whether an implied duty of good faith and fair dealing should be read into HMO-physician contracts.

As a preliminary matter, we must determine whether the Supreme Court of Pennsylvania would recognize an implied private remedy in Pennsylvania's Health Care Act or an implied duty of good faith and fair dealing. As a United States District Court exercising diversity jurisdiction, we are obliged to apply the substantive law of Pennsylvania. See Erie Railroad Co. v. Tompkins, 304 U.S. 64, 58 S.Ct. 817, 82 L.Ed. 1188 (1938).

If the Pennsylvania Supreme Court has not addressed a precise issue, a prediction must be made taking into consideration "relevant state precedents, analogous decisions, considered dicta, scholarly works, and any other reliable data tending convincingly to show how the highest court in the state would decide the issue at hand." Nationwide Mutual Insurance Company v. Buffetta, 230 F.3d 634, 637 (3d. Cir. 2000) (citation omitted). "The opinions of intermediate state courts are 'not to be disregarded by a federal court unless it is convinced by other persuasive data that the highest court in the state would decide otherwise.'" 230 F.3d at 637 citing West v. American Telephone and Telegraph Co., 311 U.S. 223, 61 S.Ct. 179, 85 L.Ed. 139 (1940).

For the reasons expressed below, we conclude that the Supreme Court of Pennsylvania would recognize an implied private remedy under Pennsylvania's Health Care Act but would not impose a separate duty of good faith and fair dealing on an HMO-

physician contract.

Pennsylvania's Prompt Payment of Claims Statute

Defendants contend that plaintiffs cannot pursue their claim under Pennsylvania's Quality Health Care Accountability and Protection Act because it does not provide for a private right of action. See 40 P.S. §§ 991.2101 to 991.2193. Plaintiffs counter that although the statute does not explicitly allow a private right of action, the Supreme Court of Pennsylvania would recognize a private cause of action in this instance and has adopted a framework for determining whether a statute implicitly provides for a private remedy. See Estate of Witthoeft v. Kiskaddon, 557 Pa. 340, 346, 733 A.2d 623, 626 (1999). In Witthoeft the Supreme Court of Pennsylvania adopted the three-pronged test used by United States Supreme Court in Cort v. Ash, 422 U.S. 66, 95 S.Ct. 2080, 45 L.Ed.2d 26 (1975).

The Superior Court of Pennsylvania recently addressed this issue and concluded that no private remedy exists. Solomon v. U.S. Healthcare Systems of Pennsylvania, Inc., 797 A.2d 346, 353 (Pa. Super. 2002), alloc. denied, 570 Pa. 688, 808 A.2d 573 (Pa. 2002). In arriving at this conclusion, the Solomon Court employed the same three-pronged Witthoeft test that plaintiffs advocate in the present case:

In Witthoeft, our Supreme Court

addressed the question of whether the Vehicle Code and its regulations expressly or implicitly provided for a private remedy for a physician's failure to report a driver's disabling condition. The Court analyzed the three factors set forth by the U.S. Supreme Court in Cort v. Ash, 422 U.S. 66, 45 L.Ed.2d 26, 95 S.Ct. 2080 (1975), for making a determination of whether a statute implicitly creates a private right of action. Those factors are:

> first, is the plaintiff 'one of the class for whose especial benefit the statute was enacted,'--that is, does the statute create a . . . right in favor of the plaintiff? Second, is there any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one? Third, is it consistent with the underlying purpose of the legislative scheme to imply such a remedy for the plaintiff? Witthoeft, 733 A.2d at 626 (quoting Cort, 422 U.S. at 78, 95 S.Ct. 2080) (emphasis in original). The Witthoeft Court also reiterated that the second factor is the "central inquiry." 733 A.2d at 626.

. . .

With respect to the first factor in the Cort analysis, we do agree that Appellants appear to be members of the class for whose benefit the statute was enacted, namely health care providers. However, "[t]he violation of a statute and the fact that some person suffered harm does not automatically give rise to a private cause of action in favor of the injured person." Witthoeft, 733 A.2d at 627. Our review of the Act reveals no indication of legislative intent, explicit or implicit, to create a private remedy. Thus the second factor, the "central inquiry," does not favor Appellants. Moreover, the regulations promulgated under the Health Care Act evidence a strong indication that no private cause of action exists. Instead, the regulations provide an administrative procedure for a health care provider to file a complaint with the

> Insurance Department. 31 Pa.Code § 154.18. Nor do we find support for the proposition that a private right exists after consideration of the third factor, whether the underlying purpose of the legislative scheme is served by implying such a remedy for Appellants. On the contrary, the provisions of the Health Care Act (and its implementing regulations) clearly set forth a system of managed health care accountability to be enforced by the Insurance Department, not by a private action in the courts.

797 A.2d at 352-353.

In Solomon the Superior Court of Pennsylvania determined that plaintiff there satisfied neither the second or third prong of the Witthoeft test and concluded that there was no private cause of action under the prompt payment of claims section of the Health Care Act. The Superior Court based its determination on the lack of legislative history in support of a private cause of action and without stating why, held this against plaintiff.

Moreover, the Superior Court found that because there was a clear system of health care accountability to be enforced by the Insurance Department under the Health Care Act this also weighed against finding that a private cause of action existed. For the following reasons we predict that the Supreme Court of Pennsylvania would recognize an implied private remedy, despite the reasoning of the Superior Court of Pennsylvania in its application of the Witthoeft test in Solomon.

Initially, we agree with the Superior Court that plaintiffs as health care providers are clearly members of the class for whose benefit the statute was enacted. Moreover, after a review of the legislative history of the statute, we agree that there is no indication of legislative intent on the part of the Pennsylvania General Assembly. However, we disagree with the three-judge panel of the Superior Court in Solomon on the effect a lack of legislative intent has in this instance. Finally, we conclude that it is consistent with the underlying purpose of the legislative scheme to imply a private cause of action and that the Supreme Court of Pennsylvania would also do so.

In support of our conclusion, we must first examine a number of relevant provisions of the Pennsylvania Statutory Construction Act of 1972.[43] Three sections of the Statutory Construction Act, §§ 1921, 1922 and 1929, are pertinent to our determination that a private cause of action is implied under 40 P.S. § 991.2166.

Section 1921 of the Act provides:

> **§ 1921. Legislative intent controls**
>
> (a) The object of all interpretation and construction of statutes is to ascertain and effectuate the intention of the General Assembly. Every statute shall be construed, if possible, to give effect to all its provisions.
>
> (b) When the words of the statute are

[43] 1 Pa.C.S.A. §§ 1501-1991.

clear and free from all ambiguity, the letter of it is not to be disregarded under the pretext of pursuing its spirit.

(c) When the words of the statute are not explicit, the intention of the General Assembly may be ascertained by considering, among other matters:

(1) The occasion and necessity for the statute.

(2) The circumstances under which it was enacted.

(3) The mischief to be remedied.

(4) The object to be attained.

(5) The former law, if any, including other statutes upon the same or similar subjects.

(6) The consequences of a particular interpretation.

(7) The contemporaneous legislative history.

(8) Legislative and administrative interpretations of such statute.

1 Pa.C.S.A. § 1921.

In addition, Section 1922 is also important to our inquiry. It provides:

§ 1922. Presumptions in ascertaining legislative intent

In ascertaining the intention of the General Assembly in the enactment of a statute the following presumptions, among others, may be used:

(1) That the General Assembly does not intend a result that is absurd, impossible of execution or unreasonable.

(2) That the General Assembly intends the entire statute to be effective and certain.

(3) That the General Assembly does not

> intend to violate the Constitution of the United States or of this Commonwealth.
>
> (4) That when a court of last resort has construed the language used in a statute, the General Assembly in subsequent statutes on the same subject matter intends the same construction to be placed upon such language.
>
> (5) That the General Assembly intends to favor the public interest as against any private interest.

1 Pa.C.S.A. § 1922.

Finally, Section 1929 of the Statutory Construction Act provides: "The provision in any statute for a penalty or forfeiture for its violation shall not be construed to deprive an injured person of the right to recover from the offender damages sustained by reason of the violation of such statute."
1 Pa.C.S.A. § 1929.

Application of Section 1921 of the Statutory Construction Act is important here because our reading of the language of Section 2166 of the Health Care Act[44] reveals that

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[44] Section 2166 provides:

> (a) A licensed insurer or managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim.
>
> (b) If a licensed insurer or a managed care plan fails to remit the payment as provided under subsection (a), interest at ten per centum (10%) per annum shall be added to the amount owed on the clean claim. Interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest to be less than two ($2) dollars.

the language is clear and free from ambiguity. However, the statute mentions no way for health care providers to collect the prompt payment of claims.

We note that Section 2182[45] of the Health Care Act provides for penalties and sanctions to be enforced by the Insurance Department, but none of the penalties or sanctions empower the Insurance Department to direct actual payment of an improperly withheld "clean claim". Rather, the penalties and sanctions provided for include civil penalties, injunctive relief and temporary monitoring by the Insurance Department to insure compliance. However, none of the penalties empower the Insurance Department to actually direct a managed care plan to pay what is outstanding to a particular provider.

In addition, as noted by the Superior Court in Solomon, prompt payment of claims is also covered in Section 154.18 of the

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(Continuation of footnote 44):
Act of May 17, 1921, P.L. 682, No. 284, § 2166 added by Act of June 17, 1998, P.L. 464, No. 68, § 1, as amended, 40 P.S. § 991.2166.

In addition, a "clean claim" is defined as:

> A claim for payment for a health care service which has no defect or impropriety. A defect or impropriety shall include lack of substantiating documentation or a particular circumstance requiring special treatment which prevents timely payment from being made on the claim. The term shall not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim.

40 P.S. § 991.2102.

[45] 40 P.S. § 991.2182.

Pennsylvania Administrative Code.[46] However, as in Section 2166 of the Health Care Act, there is no mechanism for the payment of the actual clean claims and interest to health care providers. Rather, Section 154.18 only sets forth how a health care provider is required to notify the Insurance Department of a complaint. It does not specifically authorize the Insurance Department to direct payment of any claims that are determined to be wrongfully withheld.

In Pennsylvania Blue Shield v. Commonwealth of Pennsylvania, Department of Health, 93 Pa. Commw. 1, 500 A.2d 1244 (1985), the Commonwealth Court of Pennsylvania held that while the Department of Health was empowered to grant certain types of relief including injunctive relief against Pennsylvania Blue Shield in a dispute with certain medical providers, the Department's power did not extend to the ability to grant a money judgment in favor of the health care providers.

Moreover, neither the complaint mechanism[47] nor the grievance mechanism[48] of the Health Care Act provides health care providers an avenue to collect the penalty proscribed in Section 2166 of the Act. Accordingly, it appears that nothing in the complex scheme for accountability to be enforced by the Insurance

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[46] 31 Pa.Code. § 154.18.

[47] See 40 P.S. §§ 991.2141 and 991.2142.

[48] See 40 P.S. §§ 991.2161 and 991.2162.

Department or through the internal or external complaint and grievance procedures provide for the collection of unpaid "clean claims" by health care providers.

The language of Section 2166 contains a specific entitlement to timely payment of claims and a penalty of 10% interest per annum for failure to pay promptly. However, there is no provision in the statute specifying how this should be accomplished.

In applying Section 1921(c) of the Statutory Construction Act when the words of a statute are not explicit, we may ascertain the intent of the General Assembly by looking at such things, among others, as the mischief to be remedied, the object to be obtained and the consequences of a particular interpretation.[49] Moreover, Section 1922(1) of the Act provides that "the General Assembly does not intend a result that is absurd, impossible of execution or unreasonable." Also, Section 1929 of the Act states that a provision in any statute for a penalty "shall not be construed to deprive an injured person" from a right to recover.

In applying all of the foregoing statutory construction provisions, and in the absence of specific evidence of the General Assembly's intent, we determine that it would be absurd to conclude that the Pennsylvania legislature wrote such a

[49] See 1 Pa.C.S.A. § 1921(c)(3)(4) and (6).

specific requirement for managed care plans to promptly pay the undisputed, "clean claims" of health care providers, but did not want health care providers to have the means to be made whole on the underlying claims. Nothing in the statutory scheme specifically permits health care providers to be paid through or by the Insurance Department.

Accordingly, in applying all of the above to the Witthoeft test, we conclude that plaintiffs appear to be members of the class for whose benefit the statute was enacted. Even though a review of the legislative history provides no indication of legislative intent regarding Section 2166, application of the Pennsylvania Statutory Construction Act leads us to conclude that a private cause of action should be implied because failure to do so would be absurd and would neither further the object of the statute nor remedy the mischief.

Moreover, we conclude that there is no negative consequence of our interpretation because it simply gives health care providers a remedy to be made whole separate and apart from the regulation by the Insurance Department, which is not empowered by the legislature to provide the health care providers with the money damages that would flow from this private cause of action.

Finally, in applying the third Witthoeft factor, we conclude that finding an implied private cause of action serves

the already existing regulatory scheme because it grants health care providers the ability to collect untimely "clean claims" and the statutory penalty of 10% interest per annum. Contrary to the determination of the Superior Court in Solomon, we conclude the regulatory scheme of the Health Care Act does not provide health care providers the ability to be made whole in any other way.

We do not believe that the Pennsylvania General Assembly went through the effort to enact a statute requiring health care providers to be paid on undisputed claims in a timely manner, setting forth a specific sanction for failing to do so, without implying that a private cause of action exists for the collection by health care providers of the amount of the undisputed claims and the interest due and owing on those claims if not paid within 45 days. To hold otherwise would render the language of the statute unreasonable and uncertain.

Accordingly, for the reasons expressed above, we conclude that plaintiff has set for a cause of action under Section 2166, and defendants' motion to dismiss is denied.

Duty of Good Faith and Fair Dealing

Defendants contend that plaintiffs cannot assert a contract claim for breach of an implied duty of good faith and fair dealing. Although Pennsylvania courts have recognized that

every contract implies that the parties will perform their duties in good faith, in practice the courts have recognized an independent cause of action for breaching this duty in very limited circumstances. Northview Motors, Inc. v. Chrysler Motors Corporation, 227 F.3d 78, 91 (3d Cir. 2000).

Instead, Pennsylvania courts have used the good faith duty as an interpretive tool to determine the parties' justifiable expectations in the context of contract breach. Moreover, the duty cannot be used to override an express contract term. In addition, the Court of Appeals for the Third Circuit has been unwilling to imply a separate cause of action where the allegations of bad faith are identical to a claim for relief under an established cause of action. 227 F.3d at 91-92.[50]

In Northview Motors, the Court of Appeals refused to recognize a separate cause of action for breaching the implied duty of good faith where plaintiff could have brought a suit for fraud. The Court concluded: "[W]e believe that if a plaintiff alleging a violation of the implied covenant of good faith also were to file a claim for fraud based on the same set of facts, Pennsylvania courts likely would decline to proceed with the claim alleging bad faith." 227 F.3d at 91-92. The Court of

[50] The Third Circuit has admonished that a federal court presiding over a state law claim should be reluctant to expand state common law. Northview Motors, 227 F.3d at 92 n.7.

Appeals reasoned:

> Such an approach limits the use of the bad faith cause of action to those instances where it is essential. The covenant of good faith necessarily is vague and amorphous. Without such judicial limitations in its application, every plaintiff would have an incentive to include bad faith allegations in every contract action. If construed too broadly, the doctrine could become an all-embracing statement of the parties' obligations under contract law, imposing unintended obligations upon parties and destroying the mutual benefits created by legally binding agreements.

Id.

The instant case presents a similar situation. As demonstrated by the predicate acts alleged in their RICO claims, plaintiffs could have brought their bad faith claim as a claim for fraud under state law. Plaintiffs' Complaint alleges that downcoding, bundling, capitation retention, and manipulation of the bonus frame work constitutes a breach of the duty of good faith and fair dealing. (Complaint at ¶¶ 164-166). These allegations, however, mirror plaintiffs' RICO claims based on fraud.

Moreover, in Solomon the Superior Court of Pennsylvania recently refused to allow a bad faith claim identical to the one before this court to proceed. There, an association of doctors asserted that an HMO's delay of payment did not constitute a breach of the implied duty of good faith. There the court

"[refused] to imply [a duty of good faith] simply because Appellants speculate that Appellees have failed to provide reimbursement as soon as possible." 797 A.2d at 351.

Hence, based on the foregoing, we predict the Supreme Court of Pennsylvania, would not imply a duty of good faith and fair dealing claim, when such a claim could have been brought as an action for fraud under state law. Accordingly, we grant defendants' motion to dismiss plaintiffs' duty of good faith and fair dealing claim.

CONCLUSION

In sum, the following of plaintiffs' claims are dismissed: (1) all RICO claims based on Section 1962(a); (2) Section 1962(c) and (d) mail and wire fraud claims stemming from an alleged statistically insignificant sampling of HMO member satisfaction; (3) Section 1962(c) and (d) mail and wire fraud claims based on alleged omissions of a general cost containment policy, variation of capitation rates by age and sex, inclusion of injections as part of capitated services, general averments of systematic delay and denial of reimbursement claims; (4) the Hobbs Act claim alleging inability to negotiate an arm's length contract; (5) the aiding and abetting claims; and (6) plaintiffs' state law claim regarding an implied duty of good faith and fair

dealing.

The following plaintiffs' claims survive: (1) Section 1962(c) and (d) mail and wire fraud claims stemming from "shaving" capitation payments; (2) Section 1962(c) and (d) mail and wire fraud claims stemming from manipulation of bonus criteria (except for those relating to the insignificant statistical sampling); (3) Section 1962(c) and (d) mail and wire fraud claims stemming from misrepresentations and material omissions pertaining to the payment of medically necessary services, incentives for claim reviewers to wrongfully delay and deny payment owed, downcoding and bundling of claims, and participation in risk pools; (4) the Hobbs Act claim alleging fear of economic retaliation for disputing the delay and denial of claims; (5) claims relating to bribery and Travel Act violations and (6) plaintiffs' state law claim for prompt payment of claims pursuant to section 2166.

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF PENNSYLVANIA

NATALIE M. GRIDER, M.D. and	)	Civil Action
KUTZTOWN FAMILY MEDICINE, P.C.,	)	No. 2001-CV-05641
	)	
Plaintiffs	)	
v.	)	
	)	
KEYSTONE HEALTH PLAN	)	
CENTRAL, INC.,	)	
HIGHMARK INC.,	)	
JOHN S. BROUSE,	)	
CAPITAL BLUE CROSS,	)	
JAMES M. MEAD and	)	
JOSEPH PFISTER	)	
	)	
Defendants	)	

* * *

O R D E R

NOW, this 18th day of September, 2003, upon consideration of Defendants' Motion to Dismiss filed January 23, 2002; upon consideration of Plaintiffs' Memorandum of Law in Opposition to Defendants' Motion to Dismiss Complaint filed March 6, 2002; upon consideration of Defendants' Reply to Plaintiffs' Opposition filed March 22, 2002; and for the reasons expressed in the accompanying Opinion,

IT IS ORDERED that Defendants' Motion to Dismiss is granted in part and denied in part.

IT IS FURTHER ORDERED that defendants' motion to dismiss based upon Pegram v. Herdrich,[51] the McCarran-Ferguson Act[52] and the state-action-immunity doctrine[53] is denied.

IT IS FURTHER ORDERED that consistent with the reasons set forth in the accompanying Opinion defendants' motion to dismiss Count I of plaintiffs' Complaint alleging conspiracy is denied.

IT IS FURTHER ORDERED defendants' motion to dismiss Count II of plaintiffs' Complaint alleging aiding and abetting

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[51] 530 U.S. 211, 120 S.Ct. 2143, 147 L.Ed.2d 164 (2000).

[52] 15 U.S.C. § 1012.

[53] Parker v. Brown, 317 U.S. 341, 63 S.Ct. 307, 87 L.Ed. 315 (1943).

RICO[54] violations is granted.

IT IS FURTHER ORDERED that Count II of plaintiffs' Complaint is dismissed with prejudice.

IT IS FURTHER ORDERED that defendants' motion to dismiss Count III of plaintiffs' Complaint alleging a violation of 18 U.S.C. § 1962(a) is granted in part and denied in part.

IT IS FURTHER ORDERED that defendants' motion to dismiss plaintiffs' claim of investment of racketeering proceeds under 18 U.S.C. § 1962(a) is granted without prejudice to file an amended complaint.

IT IS FURTHER ORDERED that plaintiffs shall have until on or before October 6, 2003 to file an amended complaint regarding plaintiffs' claim of investment of racketeering proceeds pursuant to 18 U.S.C. § 1962(a).

IT IS FURTHER ORDERED that defendants' motion to dismiss Count IV of plaintiffs' Complaint is granted in part and denied in part in accordance with the accompanying Opinion relating to plaintiffs' specific allegations of fraud, extortion, bribery and violations of the Travel Act[55] and Hobbs Act[56].

IT IS FURTHER ORDERED that defendants' motion to dismiss Count V of plaintiffs' Complaint alleging a violation of the

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[54] Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. §§ 1961-1968.

[55] 18 U.S.C. § 1952.

[56] 18 U.S.C. § 1951.

Pennsylvania Quality Health Care Accountability and Protection Act[57] prompt-payment provision is denied.

IT IS FURTHER ORDERED that defendants' motion to dismiss Count VI of plaintiffs' Complaint alleging violation of a duty of good faith and fair dealing is granted.

IT IS FURTHER ORDERED that in all other respects not inconsistent with the accompanying Opinion, defendants' motion to dismiss is denied.

IT IS FURTHER ORDERED that defendants shall have 20 days from service of plaintiffs' amended complaint in which to file an answer. In the event plaintiffs do not file an amended complaint by October 6, 2003, defendants shall have until October 27, 2003 to file an answer to plaintiffs' Complaint.

BY THE COURT:

James Knoll Gardner
United States District Judge

[57] Act of May 17, 1921, P.L. 682, No. 284, §§ 2101-2193, as amended, 40 P.S. §§ 991.2101 to 991.2193.